State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

Date: February 3, 2004

To: Friends of Public Health

From: Helene Nelson, Secretary

Re: Public Health Restructuring Report

As you may recall, last fall I asked a DHFS staff team to develop recommendations about ways to improve the public health delivery system in Wisconsin with these goals:

- Streamline state government;
- Eliminate redundancy in state level public health functions;
- Increase resources available in communities for effective public health work;
- Improve the state's capacity to carry out the public health mission and achieve the goals set in *Healthiest Wisconsin 2010*
- Tap into new funding sources.

I have just received their report, which you can find on the Internet at www.dhfs.wisconsin.gov/aboutDHFS/DPH/restructure/. I appreciate the diligent and intelligent work of the staff team. I am very pleased by the way that they handled this tough assignment. They have prepared a comprehensive report with extensive background information and many ideas to achieve our public health goals. They honestly tackled some controversial ideas, and looked hard at ways to streamline state operations in the current fiscal climate.

I hope you will read the report and recommendations with interest. We need your feedback and participation in developing some options further, so we can reach the best possible decisions.

For example, the report suggests that more services should be delivered at the community level. We are eager to confer with local public health agencies and officials about these ideas, and the best ways to develop a strong local public health system across the entire state. If approved, these recommendations would be forwarded to the Governor and Legislature in the context of the state biennial budget, given the need for appropriate funding and possibly statutory changes.

I have made no decisions on any of these recommendations, except those related to the internal management structure of the Division of Public Health. At the same time the Public Health Restructuring Team was working, the state Department of Administration assigned our Department, like all state agencies, targets for added state operations funding reductions in the coming fiscal year. The budget adopted by the Legislature included unspecified cuts for the Executive branch to implement.

I want to let you know that, based in part on the work of the Task Force and also on other internal management deliberations within our agency, we have made decisions about streamlining the management structure of the Division of Public Health. We will be merging bureaus and making other changes that when put in final form will be shared. While the reorganization plan is subject to approval of the state Department of Administration, approval is likely given the Governor's direction to streamline agency management and achieve savings. While a substantial portion of the savings must be returned to the state, we will retain a portion for use in new program initiatives in cooperation with community public health partners.

The Public Health Restructuring Report creates an opportunity to expand the dialogue with public health partners about how best to accomplish mutual goals. If you have written comments or questions about the report, you may submit them to the following e-mail address: DPHReview@dhfs.state.wi.us. Department managers will also meet with the Public Health Advisory Committee, WAHLDAB and various other committees and associations to discuss and receive input on the report. Finally, we will invite participation in workgroups to develop some ideas further.

Thank-you for your ongoing commitment to public health. We look forward to hearing from you.

Public Health Restructuring Report

Wisconsin Department of Health and Family Services
January 28, 2004

Executive Summary

This is a report to the Secretary of the Department of Health and Family Services prepared by department staff that develops and examines options to restructure and/or shift responsibilities for public health in a way that will improve the health of the people of Wisconsin.

There are compelling reasons for this review at this time. There are serious health problems in the Wisconsin population that must be addressed with a sense of urgency. There is limited state tax revenue to support Wisconsin's public health system. The Governor has made a commitment to the citizens to reduce the size of state government. Scarce resources must be devoted to the most serious health problems and state government must be organized for maximum efficiency so that public funds are used wisely and effectively.

This restructuring review is not being done to reduce the investment in public health or to abdicate the role of state government. The purpose is to focus and streamline the role of state government to improve state agency operations and to free up resources to invest in local government and other public health partners, and to shift some regulatory and case specific services to the local level where they can be performed more efficiently and effectively.

This is the context in which the Department Secretary chartered this review of the public health system in Wisconsin and set these goals for the project team to address in its recommendations:

- Streamline state government;
- Eliminate redundancy in state level public health functions;
- Increase resources available in communities for effective public health work;
- Improve the state's capacity to carry out the state's public health mission and achieve the goals set in *Healthiest Wisconsin 2010*; and
- Tap into new funding sources.

This report presents a series of recommendations to achieve these goals. It also includes extensive background data to describe the current structure, staffing and funding of the public health functions in DHFS and the relationship of the Division of Public Health (DPH) to local government, the universities and other state agencies. There is a suggested timetable for implementation activities for all recommendations along with an estimate of the FTE impact when known and consideration of the timing in relation to budget cycles.

The recommendations are grouped into three priority areas based mainly on anticipated impact and timing considerations, including the need for statutory change.

Priority 1. Implement major systems and organizational changes

1. Simplify the performance based contracting with local health departments.

2. Move the Bureau of Health Information to DPH.

3. Realign and integrate governance of Information Technology functions in DPH and the Bureau of Health Information.

4. Establish a Wisconsin Public Health Institute.

5. Require by law that local health departments regulate restaurants and other establishments and establish a statewide fee schedule that fully funds this service in all parts of the state.

6. Move other direct services now performed by state staff including field investigations and direct client follow-up for AIDs/HIV and STDs to local government.

7. Examine the current consortia structures to identify options that provide maximum flexibility to local government and reduce overhead, including reducing central office staffing for the Public Health Preparedness Consortia to free up funds for local government.

8. Bundle funding streams for local government to the extent possible to provide maximum flexibility and to assure core funding for community priorities.

9. Create incentives to consolidate local health departments.

10. Consider options to realign federal funding streams to improve support for the core functions of public health at both the state and local level and to align funding with health priorities, including shifting EMS services to fees.

11. Streamline the DPH organization and integrate it with the Bureau of Health Information.

12. Assess opportunities to streamline the division of labor across state agencies.

13. Simplify the internal process for awarding grants.

14. Conduct a feasibility study about adding WIC to the Food Stamp EBT platform.

15. Analyze options for a private contract for WIC vendor certification functions.

16. Analyze options for a contract with UW Extension for WIC nutrition education.

Priority 2. Reduce effort/streamline DPH central office operations

1. Discontinue regulation of tanning beds.

2. Eliminate the lead registry.

3. Eliminate the program for reproductive hazards in the workplace.

4. Shift EMS providers to a longer renewal cycle and stagger renewal dates; contract for the issuance of EMS licenses.

5. Simplify the process for awarding grants to EMS providers.

6. Modify OSHA consultation services.

7. Reduce effort spent on publications.

8. Establish/expand a contract for food distribution for the Temporary Emergency Food Assistance Program.

9. Determine if the Department of Regulation can issue credentials to Registered Sanitarians.

10. Determine if the Department of Regulation and Licensing or a private contractor can handle food manager certification requirements.

11. Sort out responsibilities within DHFS between DCFS for the Brighter Futures Program and the pregnancy prevention and related functions in DPH.

12. Sort out responsibilities within DHFS between DDES and DPH for fall prevention programs for seniors.

13. Complete the planned reduction of the Ryan White consortia from six to one.

Priority 3. Devolve other public health functions to local government

1. Move inspection of x-ray machines.

2. Move some case specific screening and case management functions in the adult and child lead programs.

3. Move some asbestos and lead abatement functions.

4. Move some occupational health consultation after environmental health is well established.

5. Shift funding in the Wisconsin Well-Woman program to permit use of GPR in the program for case management services.

6. Expand the role of local government in specific population-based functions, including training, epidemiology and professional consultation.

This report creates an opportunity to expand the dialogue with public health partners about how best to accomplish mutual goals. It is anticipated that this process will begin immediately.

The Department will seek input from a many sources in making decisions about the recommendations in this report. The leadership role of the Division of Public Health will be critical as input is considered, decisions are made about the recommendations in this report and work gets underway to implement the decisions.

I. Introduction

A. Population Health

Public health in Wisconsin is a population based system, serving all citizens, maintaining information on the health status indicators of all people, and developing programs to fit Wisconsin's needs. The vision is for healthy people in healthy communities. At this time, the Division of Public Health (DPH) of the Department of Health and Family Services is responsible for statewide population health functions such as disease surveillance and policy development as well as for many case-specific services such as environmental health investigations and the health care screening services provided by the Wisconsin Well Woman program.

Public health is defined as a system, a social enterprise, whose focus is on the population as a whole. The public health system seeks to extend the benefits of current knowledge in ways that will have maximum impact on the health status of the entire population by:

- Preventing injury, illness and the spread of disease;
- Creating a healthful environment and protecting against environmental hazards;
- Promoting and engaging healthy behaviors and promoting mental health;
- Responding to disasters and assisting communities in recovery; and
- Promoting accessible, high quality health care services.[1]

In terms of the health of the population as a whole, Wisconsin is ranked 14th this year in a national study conducted by the United Health Foundation.[2] The report's profile of Wisconsin is provided in attachment 1. This is a drop from 10th in 2002 and from 6th in the 1990 survey. In the introduction, the authors note that healthiness for individuals, families and communities is a composite of at least three essential elements:

- personal behavior and decisions;
- public policy decisions about the availability of social resources devoted to the promotion and protection of a community's health; and
- community environment that shapes the possibilities for healthiness.

The study uses a methodology that takes both risk factors and health outcomes into consideration as a way to measure these elements.

Wisconsin's overall decline in ranking in this study is partly related to a decline in health outcomes. Researchers at the University of Wisconsin conducted an analysis of the 2002 report from the United Health Foundation to determine why there was a drop in overall ranking from earlier years. [3] This analysis is useful for consideration of the 2003 report.

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[1] Wisconsin Department of Health and Family Services. April 2002. *Healthiest Wisconsin 2010: A Partnership Health Plan to Improve the Health of the Public.*
[2] United Health Foundation. 2003. *America's Health: State Health Rankings.*
[3] Wisconsin Public Health and Health Policy Institute. *Why did Wisconsin Fall in State Health Rankings?* February 2002, (vol. 3, No. 2) by Paul Peppard, Ph.D., David A. Kindig, MD, Ph.D. and Patrick Remington, MD

The report notes that the decline was largely a result of Wisconsin not keeping pace with the declines in tobacco use and infant mortality seen in the US as a whole. A further decline in overall ranking was avoided by strong improvement in heart disease risk. However, they note that position is threatened if Wisconsin continues its current trend. Wisconsin has experienced at least small decrements in rank among all the categories in this study including lifestyle, access to health care, disability, mortality and morbidity. The relative declines have been most pronounced in the lifestyle and mortality categories.

The lifestyle decisions made by our citizens have an enormous impact on our health care costs, rates of disease and mortality. Wisconsin is in the midst of an obesity epidemic. This is a staggering population health problem, ranking with tobacco use as the major preventable causes of morbidity and mortality.[4] The percentage of people that are overweight or obese has increased rapidly in recent years – doubling in Wisconsin between 1990 and 2001. Obesity related costs in the state are estimated to be approximately $1.4 billion for 2001. Responding to a public health problem of this magnitude requires leadership, coordination, and many specific action items at the individual, community and systems level. This is one example of the type of population based health activity that must be a priority for Wisconsin's public health resources.

B. Public health financing

The budget for the Division of Public Health for State Fiscal Year 2005 is $183,231,800 All Funds.

Table 1. Type and Source of Funding to DPH

	GPR	***Federal, Program Revenue and other funds***	***All Funds***
State Operations	$4,382,000	$38,931,400	$43,313,400
Local Assistance/Aids	$29,974,000	$109,944,400	$139,918,400
Total	$34,356,000	$148,875,800	$183,231,800

A detailed budget summary is provided in attachment 2.

More than three-quarters of this budget supports local assistance and aids. These funds go to a mix of agencies including:

- Local Public Health Departments;
- Tribes;
- Community-based organizations (not for profit);
- Other state agencies;
- Academic institutions;

[4] Wisconsin Public Health and Health Policy Institute. *An Ounce of Prevention: What Can Policymakers do about the Obesity Epidemic?* August 2003 (Vol. 4, No. 5) by D. Austin and R. S. Newsome

- Hospitals and clinics; and
- Other non-governmental organizations.

Of this total budget for public health in Wisconsin, less than 19% is funded by state General Purpose Revenue (GPR). This GPR commitment is used to support maintenance of effort requirements to secure federal funds and for state match requirements on federal funds.

The Department seeks to maximize federal funding for the public health system. The Division of Public Health is expected to generate $126,633,600 in federal revenue to Wisconsin for SFY 05.

The project team compared Wisconsin to seven other states, composed of the four contiguous states (Minnesota, Iowa, Illinois and Michigan) and three others that are either of similar size or are noted for the quality of their public health agency (Missouri, Oregon and Washington) to seek insight about what makes them successful. Minnesota has been among the top two states in the state health rankings from United Health Foundation since 1990 and is most like Wisconsin in terms of demographics including the percent of people aged 65 or older. Wisconsin ranks 7th among these eight states in the number of public health staff per 100,000 population.

Wisconsin spends far less than most states on public health. In its recent survey of the 50 states, the United Health Foundation cited above notes that Wisconsin's biggest challenge is low [financial] support for public health care that is 35 per cent below the average state. Wisconsin also ranks 7th among the eight states in per capita spending at the state level, 36% below the median of peer states (all funds considered). Wisconsin relies on federal funds to a higher degree than do the other peer states. A more detailed discussion of these findings is included as attachment 3.

C. Government's role in public health

The goal of public health is to secure health and to promote wellness, both for individuals and for communities. Government has a role in this goal but can not provide all aspects of health and well being for every citizen. It takes partnership, shared responsibility, and a common vision for all parties to assure this goal is met. A major revision of the Wisconsin public health statutes was completed in the 1990s so that state law is now very specific about the responsibilities of state and local government. Attachment 4 provides background information on current requirements in state law.

In 1988, the Institute of Medicine[5] reported that the American public health system, particularly its governmental components, was in disarray. The mission of public health was specified as "fulfilling society's interest in assuring conditions in which people can be healthy." The Institute of Medicine identified three core functions of public health that the government must guarantee.

[5] Institute of Medicine. 1988. *The Future of Public Health*. Washington, D.C.: National Academies Press.

Assessment: The diagnosis of community health status and needs through epidemiology, surveillance, research, and evaluation of information about disease, behavioral, biological, environmental, and socioeconomic factors.

Policy Development: Planning and priority setting, based on scientific knowledge and under the leadership of the governmental agency, for the development of comprehensive public health policies and decision making.

Assurance: The securing of universal access to a set of essential personal and community-wide health services through delegation, regulation, or direct public provision of services.

While States have a primary public responsibility for health, it is essential that residents of every community have access to public health protections through a local component of the public health system. Local government is on the front line of public health action today, providing an operational mechanism for public health action and serving as a liaison among professional experts, different governmental divisions, and the community.

Since the Institute of Medicine's report in 1988, there has been further work done to translate the three core functions into a more concrete set of activities to provide the foundation for the nation's public health strategy. Nationally this is a list of ten essential public health services. Wisconsin has further elaborated on this list to define 13 essential public services:

1. Monitor health status to identify health problems
2. Identify, investigate, control and prevent health problems.
3. Identify, investigate, control and prevent environmental health hazards.
4. Educate the public about current and emerging health issues.
5. Promote community partnerships to identify and solve health problems.
6. Create policies and plans that support individual and state efforts.
7. Enforce laws and regulations that protect health and ensure safety.
8. Link people to needed health services.
9. Assure a diverse, adequate and competent workforce.
10. Evaluate effectiveness, accessibility and quality of health services.
11. Conduct research to seek new insights and innovative solutions to health problems.
12. Assure access to primary care.
13. Foster the understanding and promotion of social and economic conditions that support good health.

The 1988 report provided the public health community with a common language and a focus for reform and set the stage for revisions to Wisconsin's public health statutes, the Turning Point Initiative and the development of *Healthiest Wisconsin 2010,* the current state health plan. The new emphasis on public health preparedness and bioterrorism over the past two years has increased the attention of citizens to the public health system and brought new resources to Wisconsin to build capacity in the system.

While good progress in improving population health has been made, a 2002 report from the Institute of Medicine (IOM) notes that demographic, technological and global changes and a shift from acute to chronic diseases as the leading killers now seriously stress the nation's public health system.[6] Chronic diseases, which are largely preventable through attention to healthy lifestyles and preventive services, cause 70 percent of all deaths each year and account for 75 percent of the nation's health care costs.[7]

In 2003 the IOM reexamined the nation's public health system to assess the changes made over the past fifteen years and to set direction for planning at the federal, state and local level.[8] As noted in their report, states and their local subdivisions retain the primary responsibility for health under the U.S. Constitution. Their report addresses the priority actions that are necessary across the nation to achieve the vision of healthy people in healthy communities:

- the need for a policy focus on population health;
- the need for greater understanding of and emphasis on the broad determinants of health; and
- the importance of strengthening the public health infrastructure.

The recommendations presented in this report are intended to focus the state's resources on this vision.

[6] Institute of Medicine. 2002. *The Future of the Public's Health in the 21st Century*. Washington, DC: National Academies Press.
[7] United Health Foundation. 2003. *America's Health: State Health Rankings.*
[8] Institute of Medicine. 2003. *The Future of the Public's Health*. National Academy of Sciences.

II. Background

A. Current structure and staffing for public health in the Department of Health and Family Services

I. Division of Public Health

There are 426.6 Full Time Equivalent positions (FTE) in the Division as of January 1, 2004.

Location	
Central office positions	345.10
Regional office positions	81.50
Funding	
GPR funded	41.58
Federally funded	249.68
Program Revenue/Other Funding	135.34

The current organization chart of the Division of Public Health includes two offices, six bureaus and five regional offices (attachment 5).

The bureaus and offices in the Division operate a wide array of programs.

Table 2. DPH Staffing and Programs by Organizational Units

BUREAU/OFFICE	*STAFFING (FTE)*	*PROGRAMS*
Office of Operations	26.8	Hospital Preparedness - administration Public Health Preparedness – administration Budget/fiscal Information technology Human Resources Communications Forms & publications Other Division support
Office of Public Health Improvement	8	Minority Health Oral Health School Health Women's Health Coordination of the State Health Plan Public Health Nursing
Bureau of Family & Community Health	67.3	Birth Defects Breastfeeding Children with Special Health Care Needs Commodity Supplemental Food Congenital Disorders Early Hearing Detection

BUREAU/OFFICE	*STAFFING (FTE)*	*PROGRAMS*
		Farmer's Market Genetics Maternal & Child Health Nutrition POCAN Reproductive Health Universal Newborn Screening Women, Infants and Children (WIC) WIC Vendor (authorization, fraud & abuse)
Bureau of Chronic Disease Prevention & Health Promotion	40	Arthritis Cancer Prevention & Control Cardiovascular Health Diabetes Guardcare J-1 Visa Organ Donor Physical Activity and Nutrition Preventive Health & Health Services Primary Care Public Health Preparedness – Education and Training Tobacco WI Well Woman
Bureau of Communicable Disease	70	AIDS/HIV Food & Waterborne Disease Surveillance Immunization Infectious Disease Epidemiology & Surveillance Public Health Preparedness – Epidemiology and Surveillance, Strategic National Stockpile Ryan White Sexually Transmitted Diseases Tuberculosis
Bureau of Emergency Medical Services & Injury Prevention	22	EMS for Children EMS Funding Assistance EMS Licensing & Certification Injury Prevention Public Health Preparedness – Planning and Assessment Rape Prevention & Education Sexual Assault Prevention
Bureau of Occupational Health	*33*	*Bureau of Occupational Health* Adult Lead Asbestos Abatement & Certification Fatality Assessment and Control Lead Abatement & Certification OSHA Consultation OSHA Lab Reproductive Hazards in the Workplace Youth Occupational Injury
Bureau of Environmental Health	70	Air Quality Asthma Childhood Lead Environmental Health Hazards Food Manager Certification Great Lakes Fish Consumption

BUREAU/OFFICE	*STAFFING (FTE)*	*PROGRAMS*
		Groundwater Quality Indoor Air Indoor Radon Public Health Preparedness – Risk Communication; Health Alert Network Radiological Protection & Monitoring Recreational Licensing Sanitarian Registration Superfund Site Assessment Tanning Bed Licensing Tattoo/Body Piercing Licensing Toxicology X-Ray Regulation
Regional offices Northern Region Northeastern Western Southern Southeastern	 17 16.5 13.5 16 18.5	All of the above
Administrator's Office including Chief Medical Officers	8	All of the above
TOTAL	426.6	

2. DPH Staff Survey

At the request of the Division Administrator, a survey of all staff in the Division of Public Health was conducted during November 2003. Some of the topics covered include opportunities for the division to be more effective and efficient, the content and implementation of the state health plan, and satisfaction with certain management practices and coordination efforts. Staff response to the survey was excellent.

In general staff responding to the survey:

- find much about the Division that is working well and needs to be continued;
- want improved communication on a wide variety of subjects, including sharing more information on priorities, activities, and roles and responsibilities of various bureaus and offices within the division;
- believe coordination within the Division is important and also think it can be improved;

- believe increased leadership is an important key to meeting the Division's goals, which will also help to promote better teamwork and to advocate successfully for the Division;
- want additional training and improved support for information technology; and
- seek streamlining and increased efficiencies in internal business processes at the division and department level, such as the printing and publications process and the process for purchasing hardware and software.

3. Bureau of Health Information

This restructuring report includes consideration of the functions of the Bureau of Health Information (BHI) because the bureau is an essential part of the public health delivery system in Wisconsin and is a partner with DPH in meeting the Department's responsibilities for population health. The core business function of BHI is to collect, protect, disseminate and analyze health care and population-based health data needed to conduct critical state business, and to collect, maintain and provide vital records for the citizens of the state.

The Bureau of Health Information (BHI), now part of the Division of Health Care Financing has five sections including Vital Records (attachment 6). With the recent transfer of key functions to the private sector, the organizational structure is under review.

B. Health Data

The practice of developing, implementing, and evaluating interventions based on sound epidemiologic studies is an essential component of the core public health function of assessment. The Division of Public Health devotes significant resources to the science of population health, and translating that science into practice.

Many staff across DPH and BHI are engaged in functions related to health data collection and analysis and to the information technology (IT) systems that support these functions. DPH has significant contracting resources to support its functions and programs. BHI functions are now largely supported by state staff. DPH has significant federal funding to support this work while BHI is facing revenue problems.

Collecting and understanding data about the broad determinants of health requires that the Department maintain a data repository. This is a data library for multiple data sources that has the IT and staff capacity to continuously receive, edit, maintain, store and provide data for DHFS customers including the Division of Public Health. BHI is the custodian of a data repository that supports its work.

Historically DPH has maintained many diverse databases containing program specific information. Over the past three years substantial progress has been made toward integrating these databases in concert with a national model that creates not only an integrated public health data system for the department but one that is consistent with

other states and federal funding agencies. Wisconsin is the only state doing co-development with CDC on the Public Health Information Network (PHIN). This partnership may position the state to secure additional federal support.

C. Grants to DPH for public health purposes

The Division of Public Health has a strong and successful policy of pursuing grants. As a result, the Division has captured a large number of grants accounting for a significant amount of funding: in CY03, DPH received 86 grants representing $153,699,200. Almost all of the grants, 75 grants or 85% of the total, are grants from the federal government. The grants range in size from $5,000 to $61.2 million and cover a wide breadth of areas. The ten largest grants administered by the DPH are listed below.

Table 3. Top Ten Grants to DPH

Grant	***Amount***
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	$61,198,335
Public Health Preparedness and Response to Bioterrorism	$18,586,482
Maternal and Child Health Block Grant	$11,603,758
Hospital Bioterrorism Preparedness Program	$9,180,277
Ryan White Comprehensive AIDS	$5,290,698
Immunization and Vaccines for Children	$5,400,939
HIV Prevention Cooperative Agreement	$3,798,016
Cancer Prevention and Control Program	$3,151,995
Preventive Health and Health Services Block Grant	$2,678,898
Epidemiology and Laboratory Capacity	$2,465,438

DPH receives two block grants, Preventive Health and Health Services Block Grant and Maternal and Child Health Block Grant that are quite flexible in their use. The remaining federal grants have more narrow and specified uses.

As of October 2003, federal grant funding supported 268 positions in DPH as follows: 46.5 positions with Maternal and Child Health (MCH) Block Grant, 32 positions with Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), 24 positions with Preventive Health Block Grant, and 166 positions with other federal grants. State staff costs represent a small proportion of the total federal grant funding. The bulk of the federal grant funding is used to contract with local entities or other

partners for public health functions, such as technical assistance, public outreach and education, surveillance, epidemiology, and to provide services to individuals. Attachment 7 is an inventory of all current grants administered by DPH.

D. Inventory of regulatory functions

At this time, the DHFS Division of Public Health is responsible for the following regulatory functions:

- Asbestos and Lead Abatement – Certification, Accreditation and Notification. There are multiple levels of certification for individuals who do the abatement work. Fees on providers support state staffing.

- EMS licensing and certification. Licenses/permits to individual EMTs (about 15,000) are issued to ambulance companies (about 450) as part of their licensing process. The Department of Transportation also plays a role in EMS regulation, as they license helicopters and inspect all ambulances.

- First Responders. DPH is required to issue permits at no cost to the individuals who meet minimum training requirements.

- Food Manager certification. Staff in the Bureau of Environmental Health performs this function. A single statewide certification process is appropriate because of the mobility of certified managers.

- Food safety and recreational licensing. About 40 local health departments perform these functions. The state conducts inspections in other areas and must prioritize inspections based on risk due to limited resources. Three other state agencies are also involved in aspects of food safety or environmental regulation – Agriculture, Trade and Consumer Protection; Natural Resources and Commerce.

- Mammography Quality Standards. This is a specialized function performed by staff in the central office of DPH. The Food and Drug Administration delegates its authority to state health departments to perform a quality assurance review, inspection and certification of all mammography devices in the state.

- Radioactive materials – "Agreement State Program". Licensing and inspecting of most radioactive materials commonly used in medicine, industry, research and education on behalf of the Nuclear Regulatory Commission (NRC). Wisconsin completed this agreement with the NRC in August 2003 to delegate its regulatory authority to the state so the owners of these materials need only one permit. This new state licensing requirement also applies to naturally occurring and accelerator produced radioactive material (NARM). Fees fund this function.

- Radiological Emergency Preparedness. Emergency response to all radioactive emergencies at nuclear power plants in or near Wisconsin. DPH serves as the State

Radiological Coordinator. Utilities are required to fund this function as part of their license from the NRC.

- Sanitarian registration. Central office staff in the Bureau of Environmental Health handles this function.

- SYNAR compliance checks. SYNAR is the commonly used name for the federal regulations that require states to monitor retail sales of tobacco products to minors as a condition of receiving federal funds. These compliance checks are done in Wisconsin by local health departments or private contractors, with state level data assembled and reported by DPH.

- Tanning bed regulation. DPH staff inspects equipment in response to complaints.

- Tattoo parlors. Local Health departments are required to handle these inspections if they have "Agent Status." In other areas, state staff does inspections.

- WIC vendor authorization. Certification of vendors and compliance monitoring is the responsibility of the WIC vendor unit in central office.

- X-ray machines –Licensing and safety inspection of x-ray tubes – about 13,000 in Wisconsin. This is funded by fees and required by statute.

E. Realigning state and local responsibilities

One component of this restructuring review is to identify ways in which regulatory functions and case-specific services now performed by state staff and the resources that support the functions could shift to local health departments. The rationale is that these services can be performed more efficiently and effectively by local health departments operating independently or in regional consortia and that they are a good fit with the mission of local health departments.

DHFS conducted a thorough review of its regulatory responsibilities within the past five years and made some adjustments as a result of this review. This included some realignment in the roles of DHFS and the Department of Agriculture, Trade and Consumer Protection.

Historically efforts to encourage the shift in responsibility for public health regulatory functions from state to local government have met with limited success. About 40 local health departments are now responsible for some regulatory functions. Attachment 8 is a map of Wisconsin showing counties with environmental health consortia and agent status Health Departments. Under state law, there are three levels of local health department certification. These are described in attachment 9.

State law authorizes and encourages partnerships with local public health departments and other state agencies, and specifies that the Department "Develop policy and provide leadership in public health throughout the state that fosters local involvement and

commitment, that emphasizes public health needs and that advocates for equitable distribution of public health resources…"[9]

The Local Health Officer is already responsible for response to food and waterborne outbreaks, and directing the environmental health staff during such episodes provides effectiveness and efficiency. Local public health programs are aware of the unique problems and needs of their local citizens, and are in a position to respond immediately to emerging issues. The freedom to determine the levels of service demanded by the community and set fees accordingly eliminates the negatives of a "one-size-fits-all" program.

This may not be an ideal time to seek to shift responsibilities from state to local government because many local health departments are facing the same kind of fiscal pressures and position cuts that face state government. However, there has been a long-standing expectation that state government should devolve some of its responsibilities to local government and that any mandates that come from the state must be fully funded. The intent of developing recommendations for shifts from the state to local government is that local health departments will be included in discussions about the recommendations made in this report and in options and incentives for structuring regional consortia.

Opportunities for regional consortia

Consortia can be an effective strategy for managing services that are shifted from the state to local government such as for the licensing of restaurants and other establishments. Formal arrangements for consortia of multiple health departments offer the opportunity to maintain a level of public health services to citizens when an individual jurisdiction is not able to provide that service efficiently or does not have adequate funding for this purpose. The use of consortia to deliver public health services encourages collaborative relationships between local health departments that may eventually lead to mergers of local health departments.

This is a worthy goal in a state with nearly 100 local health departments, many of them with very small staffs. In the current environment, many health departments expect DPH to be able to back-fill and support local agencies, especially smaller agencies when local capacity is limited; to provide extensive technical assistance and training and to fund key functions that are replicated in each agency.

There are now a variety of regional consortia with different boundaries and arrangements depending upon the set of services. DPH provides incentive funding to establish environmental health consortia. Over time some of these consortia have developed a more comprehensive array of services including licensing of food, lodging and recreational facilities. Extending this cooperation in environmental health to other areas of public health provides the opportunity to form multi-jurisdictional health departments as permitted by statute (Chapter 251).

[9] S. 250.03 (1) (g)

Other services now provided through consortia models are the Well Women and tobacco control programs. Recent formation of Public Health Preparedness Consortia have provided the opportunity to offer other public health services over multiple local public health jurisdictions including: epidemiology, surveillance, field investigation, client follow-up and training. Other program areas that could be considered for consortia are:

- Various licensing functions;
- OSHA consultation;
- AIDs/HIV;
- WIC consultation;
- Children With Special Health Care Needs; and
- More Wisconsin Well Women programs.

F. Realigning other state and university relationships

1. Related functions of universities and other state agencies

Another component of this restructuring review was to examine current relationships with universities and other state agencies to look for opportunities to improve customer service and streamline government. The chart that follows maps the connections and close relationship between the public health mission of DHFS and work done in the university system and other state agencies. The source for most of the university-related information is a report of DPH grants to the University of Wisconsin that is included as attachment 10.

Table 4. DPH Relationship with Universities and other State Agencies

RELATED PROGRAMS IN OTHER STATE AGENCIES	***AGENCY MISSION & INTERSECTION WITH PUBLIC HEALTH***	***CURRENT ACTIVITY DONE FOR DPH***
UW School of Medicine – this includes the Population Health Sciences Department, housing the Wisconsin Public Health and Health Policy Institute, the Cancer Center, AHEC, the Office of Rural Health, the Milwaukee Center for Population Health and the Dean's office with oversight for the	The Oversight and Advisory committee established by the UW Medical School to oversee public health planning efforts supported by the Blue Cross funds has set forth this mission and vision: Mission: Advance population health in Wisconsin by promoting community-academic partnerships and by supporting research and education, thereby influencing public policy. Vision: Wisconsin will become the nation's healthiest state.	*School of Medicine*: Six contracts for various programs including congenital disorders, fall prevention, HIV and oral health. *Total funding : $561,252* *Department of Preventive Medicine*: 9 contracts covering diabetes, lead poisoning, fish consumption study, mercury exposure, and EPA endocrine study. *Total funding: $1,153,763* *UW Comprehensive Cancer Center: 9* contracts for cancer control programs including the Wisconsin Well-woman Program.

RELATED PROGRAMS IN OTHER STATE AGENCIES	***AGENCY MISSION & INTERSECTION WITH PUBLIC HEALTH***	***CURRENT ACTIVITY DONE FOR DPH***
Blue Cross/Blue Shield funding		*Total funding: $1,687,090* UW Center for Tobacco Research and Intervention: *5 contracts for tobacco control.* *Total funding: $2,926,470* *Total for the Medical School: $6,328,575*
UW Madison State Lab of Hygiene	Mission: To develop and provide essential public health laboratory support to communities, agencies and private health providers consistent with the public health goals of the State.	30 contracts for a wide range of programs including environmental testing, lead hazard control, chlamydia, surveillance for communicable disease, pap testing, fish consumption study, influenza, bioterrorism and newborn screening and OSHA services. *Total funding: $6,186,137*
UW – Do It – Division of Information Technology	Mission: To create and support an Information Technology infrastructure that will allow UW System Administration staff to work together smoothly and efficiently.	16 contracts covering surveillance, systems development and maintenance and training *Total funding: $2,727,563*
UW Waisman Center	Mission: To advance knowledge about human development, developmental disabilities, and neurodegenerative diseases.	Five contracts to the Department of Medical Genetics or the Waisman Center for congenital disorders. *Total funding: $369,753 to the Department and $459,015 to the Center*
Other UW system components – including UW LaCrosse, UW Eau Claire, UW Oshkosh, Board of Regents, UW – Milwaukee, School of Nursing, Professional Development and Applied Studies, the School of Pharmacy, and the Survey Center		Generally one or two contracts per entity, covering a wide range of programs such as Tobacco, AIDs/HIV, diabetes control, Wisconsin Well-Woman Program, environmental health, arsenic evaluation, mercury exposure, and obesity prevention. *Total funding: About $1,476,586*
UW Extension	In addition to the UW System mission, the mission of Extension is to provide, jointly with the UW institutions and the Wisconsin	Six contracts for the Milwaukee Family Project, tobacco program surveillance and evaluation, bioterrorism, and WisLine services. Total funding: $199,887

RELATED PROGRAMS IN OTHER STATE AGENCIES	*AGENCY MISSION & INTERSECTION WITH PUBLIC HEALTH*	*CURRENT ACTIVITY DONE FOR DPH*
	counties, an extension program designed to apply University research, knowledge and resources to meet the educational needs of Wisconsin people, wherever they live and work. This includes the programs of the three UWEX divisions, cooperative Education, General Extension and Telecommunications.	Management of the USDA Nutrition Education Program will move from the Division of Health Care Financing to the Division of Public Health during 2004. This is a contract to provide nutrition education services to low income families in 58 counties. *Total funding for FFY 2004 is $12.7 million.*
Medical College of Wisconsin	A private, academic institution dedicated to leadership and excellence in: Education - Teaching the physicians and scientists of tomorrow while enhancing the skills of today's health professionals. Research - Creating new knowledge in basic and clinical science through biomedical, behavioral and health services research. Patient care - Caring humanely and expertly for patients and providing leadership in health services. Service - Forging local, regional, national and global partnerships in education, health care and research for the betterment of human health	8 contracts for Congenital Disorders, Family Planning, National Death Reporting System, Asthma, HIV, MCH and syphilis elimination. *Total funding is $553,673*
Department of Agriculture, Trade and Consumer Protection (DATCP)	Mission: To make Wisconsin a world leader in agriculture, food safety and consumer protection.	
Department of Natural Resources (DNR)	Mission: To protect and enhance our natural resources: our air, land and water; our wildlife, fish and forests and the ecosystems that sustain all life. To provide a healthy, sustainable environment and a full range of outdoor opportunities. To ensure the right of all people to use and enjoy these resources in their work and leisure. To work with people to understand each other's views and to carry out the public will. And in this partnership	DNR has a role in environmental regulation that intersects with DPH including for wells and septic tanks. DPH has four contracts with DNR for asthma, West Nile Virus and Bioterrorism. *Total funding: $96,796*

RELATED PROGRAMS IN OTHER STATE AGENCIES	*AGENCY MISSION & INTERSECTION WITH PUBLIC HEALTH*	*CURRENT ACTIVITY DONE FOR DPH*
	consider the future and generations to follow.	
Department of Commerce (DOC)	Mission: To serve the people of Wisconsin by promoting opportunity, safety and community.	DOC provides occupational safety consultation services to employers while DPH provides health safety consultation services to employers with less than 300 employees. The Department is also involved in regulatory aspects that intersect with DPH as they inspect weights and measures in establishments.
Department of Transportation (DOT)	Mission: To provide leadership in the development and operation of a safe and efficient transportation system.	DOT has a role in the EMS system as they license helicopters used for medical transport and inspect ambulances. The Department is also involved in population-based injury prevention programs especially related to the use of helmets, seat belts and driving while drinking.
Department of Justice/ Justice Assistance	The Wisconsin Office of Justice Assistance was created by the 1987-1989 State Budget Bill to assume the functions of the former Wisconsin Council on Criminal Justice. The agency administers justice system assistance programs under several federal funding initiatives and operates a Statistical Analysis Center, which performs a variety of functions, including managing the state Uniform Crime Reporting (UCR) system.	The Office administers at least two programs that are linked to public health: Homeland Security Violence Against Women Programs

2. Public Health Institutes

Currently 18 states, including New York, California, Kansas, and Michigan, have established private, not-for-profit public health institutes to provide a greater focus on prevention and public health, with less government. These institutes provide policy research and development, program evaluation, professional and public education, advocacy, data collection, outcome measurements and evaluations and technical assistance.

The institutes have legislative authority to act as the agent of the state health department, and thus compete extremely well for grants from federal agencies such as the Center for

Disease Control (CDC), and the National Cancer Institute (NCI), and private foundations such as the Robert Wood Johnson Foundation. Other functions include community capacity enhancement, community-needs assessments, training, and facilitation of public health partnerships.

Of the 18 current public health institutes, 13 are nonprofits under 501(c)(3). All but two are overseen by a board of directors ranging from 26 members to six. Most have a formal relationship with the state public health department and university medical schools. Staffing levels range from 570 in California to no staff in Colorado. Funding is generally a combination of state and federal funding along with grants from foundations and fees for services provided.

In Wisconsin, there is a small, existing center within the UW Medical School - the Wisconsin Public Health and Health Policy Institute. The Division of Public Health now has two small contracts with the Institute to handle various functions on its behalf. The Institute's role at this time is to serve as a focal point for applied public health and health policy within the UW Medical School as well as a bridge to public health and health policy practitioners in the state. The Medical School is expanding its mission and will become a School of Medicine and Public Health, which is expected to broaden the mission of the school and its component parts, expanding the options to align DPH work with the mission of the UW Medical School.

A public health institute could add value to the Wisconsin public health system. It could provide additional leadership for public health in the state, and serve as a bridge between the Department, university, and the private sector agencies. The institute could apply for grants on behalf of the Department for projects and programs and tap into new funding sources not available to government agencies. The institute could adopt the Public Health Agenda as its mission, and provide training, information, and resources to organizations and individuals in the state. In addition, a Public Health Institute would contribute to the growth of Wisconsin's economy by attracting and aggressively seeking public health and medical research investment and creating high-tech jobs in the medical research and health services research industries.

If a future Institute is organized and governed as a not-for-profit corporation or as an authority created in state law, its employees would not be counted as employees of state government, making it easier to staff high priority public health projects. Because the Institute would not be subject to state fiscal procedures, personnel processes and other limits placed on state government agencies, administrative and fiscal flexibility would be increased.

With this as background, three options were considered for a Wisconsin Public Health Institute:

1. An existing program within the University of Wisconsin, such as the Wisconsin Public Health and Health Policy Institute within the Medical School;

2. Creation of a 501(c)(3) not for profit corporation; and

3. Creation of a public authority, similar in concept to the Wisconsin Housing and Economic Development Authority (WHEDA).

III. Restructuring Review – Methods and Results

A. Methods

In October 2003 DHFS Secretary Nelson appointed a project team of DHFS staff to develop options and make recommendations on the most effective and efficient structure and staffing to carry out the state's public health mission.

Members of the project team:

- Tom Alt, Deputy Administrator, Division of Public Health, co-chair;
- Herb Bostrom, Director, Bureau of Communicable Disease, DPH;
- Fredi Bove, Director, DHFS Budget Office, Office of Strategic Finance;
- Patrick Cooper, Director, DHFS Office of Program Review and Audit;
- Cindy Daggett, Budget Team Leader, Office of Strategic Finance;
- Sherry Gehl, Director, Office of Operations, DPH;
- Margaret Taylor, Director, Bureau of Chronic Disease Prevention and Health Promotion, DPH;
- Robert Wagner, Chief, Evaluation Section, Office of Strategic Finance; and
- Susan Wood, DHFS manager, co-chair.

In order to review current operations and identify options for restructuring, twenty key functions were identified that are performed by staff of the Division of Public Health. While the definition of each function may vary somewhat from bureau to bureau, this was a helpful way to understand the scope of work across the Division. In addition to the functional review, specific program areas and funding streams in the Division of Public Health were reviewed, there was a review of the Department's prevention programs to identify opportunities for improved services, and the team considered results from a survey of selected states and the results of the staff survey conducted in November 2003.

For all functional and program areas reviewed, these options were considered:

- Stop doing it;
- Reduce effort;
- Streamline the way business is done;
- Shift functions/programs to a Public Health Institute;
- Shift functions/programs to local health departments and/or regional consortia;
- Contract with other public or private agencies; and
- No change.

The list of functions considered and the outcome of this preliminary review is described in a table of the restructuring options that were considered (attachment 11). For a number of activities or functions, more than one option was identified. The recommendations for this report were then developed based on synthesizing these options with the following assumptions and criteria.

1. The Department remains responsible for leadership of the state's public health system. Therefore it is important that the Department maintain control of public health data, funding, program direction and mission.

2. The role of the Department and Health and Family Services should change to focus most of its resources on population-based health functions that are essential to the public health mission.

3. To focus on population health and to free up state level resources to support local health departments, the Department should shift both the regulatory functions and the case-specific services it now performs to local health departments to the extent this is possible.

4. Funding must accompany shifts in responsibilities.

5. Improving the partnership of state government with both local government and with the University of Wisconsin can strengthen the public health system and is compatible with the mission of local government, the University and the Department.

6. Other contracting options that add value to the public health system and are cost-effective should also be pursued.

7. In considering if state government could stop performing certain activities, there was consideration of the possibility of redirecting GPR funding to higher priority areas as well as of how well the activity fits with the core mission of the agency, and if can it be done in other ways.

8. In considering recommendations for streamlining state government, there was consideration of reducing effort devoted to a particular function or program as well as to ideas for doing business in other ways.

9. In considering options for a public health institute, there was consideration of the value that would be added to the public health system and if the option is consistent with the mission of the University or the core mission of other public health institutes.

10. For the activities that might be moved to local government, it was assumed that adequate funding would be provided. And it was assumed that almost all regulatory and person specific activities now performed by state staff should be considered as a good fit with the mission of local health departments. Also, there was recognition that barriers need to be understood and addressed for this to succeed including issues with the Department of Agriculture, Trade and Consumer Protection.

11. Local health departments would have the option to perform the service directly or to contract with a vendor for the service and could continue to join with others into consortia of their own choosing.

12. It is important to build capacity at local government for essential population-based public health services including surveillance, epidemiology and professional consultation/technical assistance and to be clear about the respective roles of state and local government and how they intersect at the individual, community and systems level.

13. In considering other contracting options, potential costs were considered including the need to maintain state staff to procure services and monitor vendors. Programs or functions now contracted to outside vendors were considered to see if additional projects could go to these vendors, as well as if there are vendors available in the marketplace to provide the service.

14. The organizational structure of DPH will change to reflect the plans for expanded relationships with the University and creation of a Public Health Institute and the evolvement of responsibilities and funding from state to local government. There will be a number of options for a more streamlined administrative structure in the central office and a fresh opportunity to look at the division of labor between the central and regional offices of DPH.

B. Results - Recommendations for restructuring public health functions in DHFS

The recommendations for restructuring the Division of Public Health and the Bureau of Health Information are grouped into three priority areas based mainly on anticipated impact and timing considerations, including the need for statutory change. Attachment 12 provides a proposed timetable for all recommendations, including an estimate of the FTE impact when known and consideration of the timing required to implement the recommendation, including appropriate changes in state law.

Priority 1: Implement major systems and organizational changes

1. Simplify the performance based contracting process with local health departments.

    a. To do so, change the current performance based contracting process to simplify the process without losing focus on the goals.

    b. It is recognized that this is now taking enormous state and local resources. There are many people involved in this in both regional offices and central office. The expectation is that staff time will be freed up to focus on other high priority work.

    c. Streamlining the process would free up DPH staff time to assign to higher priority work (such as nurses and nutritionists who were shifted to this work) and also free up time of management and staff in local health departments.

    d. Use the existing steering committee of state and local staff to examine all options and assumptions including how best to create the proper mix of incentives and

disincentives for good performance and to consider credentialing and accreditation of local health departments.

e. Consider thresholds based on the amount of funds involved.

f. Look at other department models of funds to local government to see if there are best practices to apply to public health.

g. Other options to examine as part of this review are the option to have local health departments conduct formal self-assessments or peer reviews to reduce the level of effort of state staff and opportunities to blend this with the "Chapter 140 Reviews" of local health departments done on a five year cycle.

2. Move the Bureau of Health Information (BHI) to the Division of Public Health.

   a. There is considerable overlap in the functions of BHI and DPH and opportunity to improve customer service and control costs while streamlining operations.

   b. Maintain the links between the vital record section and other BHI functions of health data collection and analysis because vital records are one of the largest health data sources (birth and death records) in Wisconsin.

   c. Maintain the current staffing in BHI to meet the Department's focus on population health and the need for a greater understanding of and emphasis on the broad determinants of health.

3. Realign and integrate governance of Information Technology functions in the Division.

   a. Information Technology services and functions are now performed across DPH with as many as 35 applications and databases under development with many contractors involved. Improving coordination and project management efforts should create efficiencies.

   b. Streamline IT functions and integrate them with like functions performed by the Bureau of Health Information now in DHCF including consideration of staff needs and funding to maintain a public health data repository.

   c. Assure that DPH has an appropriate governance structure to manage all of its IT business requirements and has access to staff with the right set of business skills to manage this outsourcing. Complete on-going efforts to establish an improved governance structure for planning, coordinating and managing DPH Information Technology (IT) projects.

d. Review with the intent to continue the current contracts for the development and maintenance of the Public Health Information Network (PHIN) and related systems and for claims payment for the Wisconsin Well-Woman Program.

e. Continue the ongoing effort to move vital records to a Web-based IT system with the capacity to electronically share data across the state.

f. Surveillance and Epidemiology is a core function of state government and requires significant resources. Some aspects may be appropriate for contracting with a public health institute or other parts of the university system. Once contracting decisions are made, there should be opportunities to achieve efficiency in this area by maximizing IT systems, linking to BHI and in database management.

g. Efforts should be made to streamline and improve procedures for purchasing IT hardware and software. Staff is confused and frustrated with the IT acquisition process and considerable staff time is spent on paperwork justifying decisions.

h. Database management is a growing workload, and it may be possible to merge some of the standalone data sets or to realign functions. There are significant resources in DPH devoted to these functions.

i. There also is a need in DPH and throughout the department to upgrade software to versions that are most efficient and meet standards of federal funding agencies. Relying on old versions creates inefficiencies and limits program staff opportunities. One bureau reported declining a federally designed and funded IT application because it was built with the most recent version of software that was not compatible with the current DHFS network and programs.

4. Establish a Public Health Institute

a. Conduct an in-depth analysis of the options before the state and the feasibility of creating either a not-for-profit corporation or a public authority to develop a proposal for the 2005 – 2007 biennial budget. This analysis will include if and how it would be affiliated with the University of Wisconsin in general, the UW – Extension, the UW Medical School and the Blue Cross/Blue Shield Program within the Medical School. It will also consider options with the Medical College of Wisconsin including their Consortium on Public and Community Health, the entity that manages the Medical College's proceeds from the Blue Cross/Blue Shield Program. The desired outcome is an institute that will support the entire state public health system and enhance the leadership role of the state health department.

b. Continue the current ad hoc relationship with UW Public Health and Health Policy Institute for the short term, so that projects can continue and newly funded projects that fit with the Institute's mission can get underway.

c. Consider a more formal arrangement with the University for the short term with a MOU plus designation of staff in DPH responsible for coordination and leadership. There may be a benefit to the state to formalize a relationship with the University as an agent of the state to seek new funding for public health priorities. DPH currently has contracts of more than $17 million with the UW system.

d. Consider shifting other functions or tasks now done in DPH to the existing Public Health and Health Policy Institute at UW or to other university partners until a formal institute can be developed. To the extent this is done, there are policy considerations to resolve including the leadership and coordination for these efforts; how to avoid inefficiencies in terms of indirect costs, supervision; the impact on state position counts; and the administrative costs involved in getting programs started. The functions that could be moved to university partners include:

- the coordination and planning now done in the Office of Public Health Improvement for the state public health plan and women/minority health;
- some aspects of grant and program development and program management such as seeking funds, grant writing, staffing projects, coordination, preparation of reports to funding agencies;
- policy development, research, development of issue papers;
- program evaluation, including the current contracts with the Medical Schools for evaluation of the AIDs and tobacco control programs;
- aspects of surveillance (data collection and dissemination) and epidemiology;
- tasks involved in professional consultation, technical assistance and training such as production and dissemination of public information products, professional education
- population-based nutrition education now done in the WIC program;
- population-based functions that support the Children with Special Health Care Needs program (if other alternatives are not pursued); and
- IT functions that could go to an Institute include management, applications development, system maintenance.

5. Require by law that local governments regulate restaurants and other establishments as a replacement for the current situation that has two levels of inspection based on the government agency that handles these functions. This would shift work now done by state staff in certain parts of the state to local government so that there is a uniform system statewide. To support this shift, establish a statewide fee schedule that fully funds the service in all parts of the state so that the mandate is funded.

a. A voluntary approach has not succeeded.

b. The current fee schedule used to support this function is inadequate to support the frequency of inspection required by contract of agent health departments. This

results in agents having to charge higher fees than the state does which is a significant disincentive for development of new agents.

c. Actual delivery of inspection, licensing, and regulatory services would occur at the local level.

d. With this transition, the primary future role of the State is envisioned as a resource for training, policy development, rules maintenance and oversight. The regional offices would continue to work with local health departments and each region would have one or more Regional Coordinators to assist with training and evaluation. Policy, codes, rules, and large-scale training would continue to be a function of the Central Office.

e. Consider how best to streamline the relationship between local and state government including the Departments of Agriculture, Commerce and Natural Resources.

6. Move other direct services now performed by state staff, including field investigations and direct client follow-up for AIDs/HIV and STDs to local government.

7. Examine the current consortia structures to identify options that provide maximum flexibility to local government and reduce overhead, including reducing central office staffing for Public Health Preparedness to free up funds for local government.

8. Bundle funding streams for local government to the extent possible to provide maximum flexibility and to assure core funding for community priorities.

   a. Shifting a number of functions from state to local government will add funding to the current mix of funds that support local health departments and it is an opportune time to reexamine goals and how allocation methods support these goals.

   b. As part of this analysis, consider setting formulas that are based on countywide data regardless of the structure of the local public health agencies within the county. This would reduce the effort that goes into the contracting process and is a way to establish a wider population base for public health planning and capacity building.

9. Create incentives to consolidate local health departments.

   a. There are now almost 100 local health departments that require DPH services and that DPH is obligated to supervise.

   b. Emerging public health issues require a broader base for planning and intervention.

c. This is an opportune time to examine the incentives and constraints to consolidating local health departments as Public Health Preparedness and Bio-terrorism planning brings a new imperative to plan on a broader scale and is the funding vehicle to build infrastructure for this purpose.

10. Consider options to realign federal funding streams to use the Preventive Health and Health Services Block Grant and the Maternal and Child Health Block Grant to support core functions of public health at both the state and local level and to align funding with health priorities, including shifting EMS services to fees.

    a. The Preventive Health and Health Services Block Grant.

        1. Funding is about $2.7 million per year.

        2. It funds parts of many people across DPH except for Family and Community Health, including a large part of the regional structure. About $1.2 million goes to state operations and it is the major funding source for EMS.

        3. Contracts with local health departments use about $900,000 to $1.2 million.

        4. It is a very flexible funding source that can be used to fill gaps.

        5. It has been an important source of funding for the implementation of the Public Health Plan and for community needs assessments.

        6. $45,000 is set aside each year to support the start-up costs for regional environmental health consortia.

        7. There has been a long-standing commitment in DHFS to commit 50% of the block grant to local health departments.

        8. The overall level of funding has been going down over the past few years.

    b. The Maternal and Child Block Grant.

        1. Total funding is about $12 million per year.

        2. It funds the staff in the Bureau of Family and Community Health and many of the regional staff.

        3. Local agencies contribute to the state match through in-kind contributions.

        4. It is also a very flexible funding source in general although under federal requirements 30% must go to the Children with Special Health Care Needs component.

c. Emergency Medical Services (EMS).

    1. Shift costs of EMS administration from the Prevention Block Grant to fees – and increase driver license fees to support EMS.

    2. This would free up funds for core functions – which is the purpose of the block grant.

    3. Also consider contracting this aspect of program administration to a private vendor or shifting the function to the Department of Transportation as this agency is now involved in some aspects of EMS.

d. Work with local health departments to describe the desired system, how it should be financed, how the state should distribute funds to local health departments, and how to build support for core funding of public health. This supports a key objective of *Healthiest Wisconsin 2010*, the current state plan, to establish equitable, adequate and stable funding for the public health system.

11. Streamline the DPH organization and integrate it with the Bureau of Health Information to reduce overhead, reduce redundancy, expand the span of control of management staff and improve program outcomes. Depending upon decisions that are made about new relationships with the university and shifting responsibilities and funding from state to local government, there will be many opportunities for a more streamlined administrative structure in the central office and its division of labor with the regional offices. These recommendations envision a structure that is viable now for DPH and the Bureau of Health Information in DHCF and one that is viable in the future with an expanded role for local government and the creation of a Public Health Institute.

    a. Move the Bureau of Health Information in DHCF including Vital Statistics to DPH. Combine the current BHI with overall planning and IT functions now in DPH to create a Bureau of Health Planning and Information to strengthen the policy focus on population health and the data systems that support the core functions of public health. In addition, review those functions within the department and the statewide context for appropriate placement.

    b. Merge the Bureaus of Environmental and Occupational Health. This would consolidate regulatory functions that remain in the central office once some functions are moved to local government.

    c. Merge the Bureaus of Family and Community Health and Chronic Disease Prevention and Health Promotion to create a Bureau of Prevention and Health Promotion that will help support the Department's efforts to focus on key priorities in the state health plan and to reduce redundancy in functions and programs.

d. Align the functions now provided by the Bureau of Emergency Medical Services and Injury Prevention with this new structure. Move the injury prevention functions to the new Bureau of Prevention and Health Promotion and move the EMS licensing to the combined Environmental and Occupational Health Bureau, the Operations Section or to the Department of Transportation.

e. Align the functions now provided by the Office of Public Health Improvement with this new structure. Move oral health program staff and the functions of the Women's Health Officer to the new Bureau of Prevention and Health Promotion. Move the critical planning functions including the coordination of the state health plan, public health nursing, and the minority health officer position to the new Bureau of Health Planning and Information.

f. Children with Special Health Care Needs – examine options to integrate the central office roles for the Children with Special Health Care Needs program with the Birth to Three and Katie Beckett programs in DDES. Also, consider options to reduce effort in the central office roles to free up funds for direct services and consider options for shifting responsibility and funding for the case management component of the Children with Special Health Care Needs program to local government – instead of contracting with 5 regional centers, determine if it is feasible to fund local health departments or regional consortia of health departments to provide service to this population.

g. Streamline processes for grant management and contract management between the Operations Section and the new bureaus and with rest of the Department.

h. To the extent staff who handle grant and program development and program management are shifted to a Public Health Institute, realign staff roles within DPH for the management and support staff that remain – and include support for these positions as new grants are written.

i. Sort out tasks involved in professional consultation, technical assistance, training and risk communication across bureaus and between central office and regions to focus on highest priorities, fill gaps and eliminate redundancy.

    1. This is a critical role for state government and it is closely connected to policy development functions.

    2. The audience for this work is local health departments, clinicians, health care providers, and community-based organizations and in some cases the general public.

3. An example of the work in this area is assistance to local health departments when there is an outbreak of communicable disease.

4. There is opportunity to improve communications with local health departments and use people's time more efficiently by streamlining the use of advisory committees and using teleconferencing.

5. Another avenue to explore is full utilization of distance learning strategies to use staff time as efficiently as possible and create more opportunity for participation by partners.

j. Streamline physician and engineering services

1. As these are high cost positions, consider sharing of medical officers and engineers across programs and divisions in the Department and consider if some tasks now performed by these positions could be reassigned to other staff.

2. Eliminate one Chief Medical Officer position in DPH as part of the reorganization to align services to the new structure for program bureaus and as a way to reduce costs.

3. Assign Chief Medical Officers to report to the Bureau Directors.

k. Regional Offices

1. Assure that regional staff remain available to support the local public health service delivery system. Once decisions are made about functions that move out of DPH, the division of labor between regions and central office staff can be reviewed. This would focus on the functions that remain in DPH including compliance monitoring, policy development, technical assistance and professional consultation.

2. Assure adequate staffing to support the transition of direct services from the state to local government.

3. At a later date, once responsibilities are shifted to a public health institute and to local government, the Department should determine if there are benefits to merging DHFS regional staff into one coherent organization that supports the Department's mission.

12. Assess the opportunities to streamlining the division of labor across state agencies to improve customer service and reduce costs. For example, as the food service industry has evolved, with delis in grocery stores and new catering options, there is more overlap in the regulatory roles of DHFS and the Agriculture Department, both

of which are involved in various aspects of food safety. There is also overlap in the area of environmental health regulation between DNR and DHFS.

13. Simplify the internal process for awarding grants (rather than using the process set up to procure commodities) to reduce the effort that goes into this now.

    a. In reviewing options for simplifying the granting process, consider working and coordinating with the other DHFS divisions that are extensively involved in issuing grants. Some policy or procedural requirements may work for multiple divisions.

    b. There may also be ways to streamline the current process within DPH by consolidating functions in the Operations Section for the preparation of fiscal forms for grants.

    c. If the procurement process can be simplified for all of DPH, considerable effort can be saved in writing RFPs, conducting vendor conferences, and review of proposals.

    d. As part of this effort, it is recommended that an inventory be created of the number of times the RFP process is used as opposed to formulas or negotiation.

14. Conduct a feasibility study about adding WIC to the Food Stamp EBT platform. The vendor supporting EBT has offered to reduce its price to Wisconsin if other programs can be added to the Food Stamp EBT system.

15. Analyze options for a private contractor for WIC vendor certification functions of field investigations and other onsite compliance monitoring. It is assumed that DPH would retain staff to supervise the vendor and apply sanctions when needed.

16. Analyze options for a contract with UW Extension for WIC nutrition education. During 2004, DPH will assume responsibility for the management of the DHFS contract with UW-Extension for the Nutrition Education Program for Food Stamp recipients. There may be duplication with services now provided by DPH and there may be opportunities to improve service delivery overall.

Priority 2: Reduce effort/streamline central office operations

1. Discontinue the regulation of tanning beds. This is not required by current law and is not as high a priority as other regulatory functions.

2. Eliminate the Lead Registry – this is a registry for landlords and day care centers to document the status of their buildings in relation to lead hazards. The registry has not accomplished its purpose. Alternative means to achieve the goal can be developed.

3. Eliminate the program for Reproductive Hazards in the Workplace – this program provides on-site risk assessment and case management to individuals. While this is a safety issue and a good service to citizens, it is not considered to be as essential as other public health services.

4. Shift EMS providers to a longer renewal cycle (3 years instead of 2) and stagger the renewal dates in the future instead of issuing all renewals in June of even numbered years. Streamlining the process will avoid the current practice of redeploying staff from across the Division at peak times. Also analyze options to shift the issuance of licenses for EMS providers to a private contractor, either just for EMS or along with other DHFS licensing.

5. Simplify the process for issuing grants to EMS providers. This is a discretionary activity for public health, funded by GPR, that requires a high level of administrative support.

    a. EMS funding assistance became law in 1989, to provide supplemental funding for EMS operations and training for services run by municipalities, tribes, volunteers or non-profits.

    b. The program provides $2.2 million each year, $800,000 of which is set aside for training (basic and refresher). The remaining $1.4 million can be used for vehicles, equipment, supplies or training. It can be escrowed from year to year to purchase more expensive equipment that is needed. The supplement is distributed on the basis of a formula: $3,588 for each service plus $0.03 per capita (verified by town treasurers in the application form). This supplement ranges from < $4,000 to about $22,000 and provides 5% or less of the costs of each service.

    c. The $800,000 available for training is paid directly to training centers (tech schools and a couple of hospitals) when a class completes training. These funds provide a significant proportion of the resources for training EMTs in Wisconsin. Any money left over at the end of the year ($100,000 - $200,000) is distributed equally among the 400 EMS providers.

6. Modify OSHA consultation services.

    a. Reduce the level of service to the minimum federal requirements.

    b. Consider assigning some consultation work to trained sanitarians instead of engineers.

    c. Also finalize the plan developed within the past few years to shift occupational health consultation for large employers from the Department of Commerce to DPH so that employers deal with just one agency in state government for this purpose.

7. Streamline the Department's approval process for publications providing public information, risk communication and health promotion to assure timely release of information and to reduce the level of effort expended now by DPH staff to get products released.

    a. Shepherding documents through the current process is very time consuming for staff.

    b. There is a study underway in the Department that will make recommendations as to how to accomplish this.

8. Establish/expand a contract for the food distribution component of the Temporary Emergency Food Assistance Program (TEFAP). Potential vendors include DATCP, Hunger Task Force, Second Harvest, or CAP agencies.

9. Sanitarians – credentials. Analyze options to shift this work to the Department of Regulation and Licensing. If the function remains in DPH – reduce effort for this activity including the possibility of using a new Internet based registration system that OCI is implementing for insurance agents.

10. Food manager certification - Analyze options to have this done either by the Department of Regulation and Licensing or by a private contractor.

11. Sort out responsibilities in DHFS for the Brighter Futures initiative, managed by the Division of Children and Family Services and the pregnancy prevention and related programs in DPH to minimize redundancy.

12. Sort out the responsibilities in DHFS for fall prevention programs managed by the Division of Disability and Elder Services and DPH to minimize redundancy.

13. Complete the planned reduction of the number of "Ryan White" consortia from six to one to reduce effort in contract administration and program management.

Priority 3: Devolve other public health functions to local government

1. Move regulation of x-ray machines.

2. Move some case specific screening and case management functions for the adult and child lead programs.

3. Move some asbestos and lead abatement functions.

4. Move some occupational health functions to local government after other environmental health functions are well established.

5. Shift funding in the Wisconsin Well-Woman program to permit use of GPR already funding the program to be used to support case management provided by local coordinators.

6. Expand the role of local government in essential public health services including surveillance, epidemiology and professional consultation/technical assistance, with financial support to do so without compromising the state level responsibilities for these functions.

    a. There is now $1.2 million in Public Health Preparedness funding to create epidemiologist positions in each region of the state plus funds to create a training officer in each region.

    b. Consider working with a Public Health Institute to help build capacity for local health departments for these functions.

Impact of Recommendations

As requested this is a high level view of options to restructure the Wisconsin public health system. The report makes recommendations that will now be considered by the Department and by the public health community. It is vital to have input from local public health staff and others engaged in the work of public health in Wisconsin about the recommendations in the report that have an impact outside of the Department.

To the extent that current positions in DPH are eliminated by these recommendations, one important consideration is the loss of excellent staff with little seniority in the civil service. The public health workforce in the nation, including Wisconsin, is aging. It is essential to provide opportunities for public health professionals of all ages to work in their chosen field and to keep their talents in Wisconsin. It is anticipated that there will be opportunities for state staff to be hired by local government and that by creating a Public Health Institute, there will be new opportunities for public health professionals to have great jobs in Wisconsin.

In considering options to contract for services now provided by state staff, the cost benefit assessment must take into account the need to maintain state staff to manage programs, find vendors and monitor the services provided by vendors. The Division of Public Health remains responsible for assuring that citizens have universal access to a set of essential services whether they are provided through delegation, regulation or direct provision of services.

The leadership role of the Division of Public Health will be critical as input is considered, decisions are made about the recommendations in this report and work gets underway to implement them. In comments provided by local government representatives and in the staff survey done in December 2003, a prominent issue is leadership. The work done for this report will support the leadership role of DPH – creating an opportunity to expand

the dialogue with partners about how best to accomplish mutual goals and align funding to the state's top health priorities. This process can begin immediately.

This is a set of recommendations to streamline state government; eliminate redundancy in state level public health functions; increase resources available in communities for effective public health work; improve the state's capacity to carry out the state's public health mission and achieve the goals set in the Public Health Plan for 2010; and tap into new funding sources. Most recommendations impact multiple goals. They position Wisconsin to accomplish the priority actions set out by the Institute of Medicine as necessary to achieve the vision of healthy people in healthy communities.

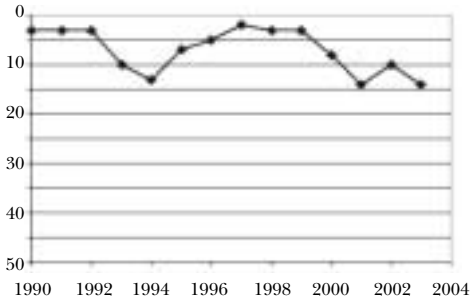
Attachments

WISCONSIN

Wisconsin is 14th this year, down from 10th in 2002. Its strengths are a low rate of uninsured population at 9.8 percent, a low violent crime rate at 231 offenses per 100,000 population, a strong high school graduation rate at 78.2 percent of incoming ninth graders who graduate within four years and a low incidence of infectious disease at 8.3 cases per 100,000 population. Wisconsin's biggest challenge is low support for public health care that is 35 percent below the average state. Adequate prenatal care is received by only 59.9 percent of pregnant black women compared to 80.5 percent of pregnant white women, indicating disparity in health within the state. Wisconsin is 14th for the combined measures of risk factors and 13th for the combined measures of outcomes. This indicates that the state's relative health is likely to remain steady in the near future. In the past year, the rate of cancer deaths decreased from 209.5 to 205.7 deaths per 100,000 population. Since 1990, the infant mortality rate has decreased from 8.9 to 6.8 deaths per 1,000 live births, and support for public health care has declined from 19 percent above the average state to 35 percent below average.

To learn more about health and health initiatives in Wisconsin, visit the Wisconsin state department of health Web site at: www.dhfs.state.wi.us/

OVERALL RANK



RANKINGS				MEASUREMENT DATA		
2003	2002	1990	RISK FACTORS	2003	2002	1990
28	26	6	Prevalence of Smoking (Percent of population)	23.3	23.6	26.3
22	11	8	Motor Vehicle Deaths (Deaths per 100,000,000 miles driven)	1.4	1.3	1.9
6	6	11	Violent Crime (Offenses per 100,000 population)	231	237	250
18	19	50	Risk for Heart Disease (Percent above or below national average)	-6	-3	18
7	9	9	High School Graduation (Percent of incoming ninth graders)	78.2	76.9	83.7
16	16	9	Children in Poverty (Percent of persons age 18 and under)	12.0	11.4	12.6
21	20	4	Adequacy of Prenatal Care (Percent of pregnant women)	77.6	77.7	78.6
3	2	6	Lack of Health Insurance (Percent without health insurance)	9.8	7.7	8.3
49	35	9	Support for Public Health Care (Ratio)	1.13	1.29	0.9*
			OUTCOMES			
16	10	14	Occupational Fatalities (Deaths per 100,000 workers)	4.6	4.2	7.8*
7	7	11	Limited Activity Days (Days in last 30 days)	1.6	1.6	2.9*
20	18	23	Heart Deaths (Deaths per 100,000 population)	244.6	250.8	306.3
27	28	20	Cancer Deaths (Deaths per 100,000 population)	205.7	209.5	195.7
9	4	6	Infectious Disease (Cases per 100,000 population)	8.3	7.4	14.1
22	21	16	Total Mortality (Deaths per 100,000 population)	841.1	854.5	833.2
23	20	8	Infant Mortality (Deaths per 1,000 live births)	6.8	6.7	8.9
17	12	7	Premature Death (Years lost per 100,000 population)	6575	6623	7143

* Data sources and/or methodology may not be comparable for this year.

Public Health Restructuring Report Attachment 2 - Division of Public Health Budget Summary

FY05

	Operations	FTE	Aids/Local Assistance	
GPR	$4,382,000	41.58	$29,974,000	$34,356,000
HIV			$4,208,800	
Well-Woman Program			$2,188,200	
Cancer Control and Prevention			$394,600	
Services for Homeless Individuals			$125,000	
Emergency Medical Services			$2,200,000	
Dental Services			$2,970,500	
Rural Health Dental Clinics			$587,600	
Statewide Poison Control Program			$375,000	
TB			$391,900	
Radon			$30,000	
Lead Poisoning/Exposure			$1,004,100	
Pregnancy Counseling			$77,600	
WIC			$179,300	
Pregnancy Outreach and Infant Health			$211,200	
Family Planning			$1,955,200	
Community Health Services			$3,075,000	
Tobacco Use Control Grants			$10,000,000	
			$29,974,000	
Program Revenue	$10,351,700		$11,599,300	$21,951,000
Congenital Disorders			$1,929,300	
Minority Health			$150,000	
Cooperative American Indian Health Projects			$120,000	
Interagency and Intraagency Aids			$9,400,000	
			$11,599,300	
Lead Abatement Certification	$696,500	10.50		
Sanitarian Registration	$11,400			
Licensing, Review and Certifying Activities	$3,361,100	46.50		
Radiation Protection	$1,718,600	17.65		
Radiation Monitoring	$177,400	1.00		
Tanning Fees	$16,700	0.20		
Asbestos Abatement Certification	$457,700	6.30		
WIC	$1,000			
Gifts and Grants	$283,600	0.50		
Congenital Disorders; Operations	$50,600			
Interagency/Intraagency Programs	$3,577,100	20.00		
	$10,351,700	102.65		
Federal Revenue	$28,288,500		$98,345,100	$126,633,600
Federal Project Aids	$16,720,100	151.67	$33,574,600	
Preventive Health Block Grant	$2,015,500	25.53	$2,450,000	
Maternal and Child Health Block Grant	$5,104,400	45.80	$7,895,600	
Federal WIC Aids			$54,424,900	
Medical Assistance State Administration	$249,200	2.29	$98,345,100	
Federal WIC Operations	$4,199,300	31.73		
	$28,288,500	257.02		
SEG				
Groundwater and Air Quality Standards	$291,200	2.57		$291,200
TOTAL	$43,313,400	403.82 *	$139,918,400	$183,231,800

*FTE count is at end of FY05, not current number of FTE on PIVS.

Public Health Restructuring Report
January 28, 2004
Attachment 3

Comparing Wisconsin to Peer States: Funding, Staffing and Outcomes

To understand the context for our effort to develop options for restructuring the Division of Public Health, we examined models in several other states. We choose those states that are contiguous to Wisconsin and several others that either serve similar populations or are noted for the quality of their agency. In all we included Minnesota, Iowa, Illinois, Michigan, Missouri, Washington, and Oregon. We examined their structure, resources and interaction with other providers including local public health agencies. We also reviewed a recent evaluation of the effectiveness of public health activities as measured by various health status indicators for this group of comparable states. The source of the information health outcomes is from the recently released report by the United Health Foundation, which compared the performance of the 50 states on eight public health outcomes.

For staffing, budget, and other pertinent information on public health agencies in the 7 other states, we relied on information collected from each state's website, interviews with key managers and staff, and information e-mailed to us from managers we spoke with in these states. In those instances in which responses from a state appeared significantly out of line with responses we received from other states, we double-checked this information to ensure its accuracy. However, as with any survey of other states, the accuracy of the information presented is largely dependent upon the surveyors and respondents having a common understanding of key terms, and respondents truly understanding the information being requested and providing the correct information.

Five of the eight states we surveyed are governed by boards. Three of these boards set policy, while two are advisory. Five of the eight, not including Wisconsin, work in collaboration with a Public Health Institute. The structure of the public health agencies in these states varied in structure and scope:

- ✓ In three of the states (including Wisconsin), the public health agency was part of a larger human services department, while in the rest the public health agency is its own department.

- ✓ In three of the states (including Wisconsin), the agency that runs public health is also the state Medicaid agency.

- ✓ In general, most other states had public health departments that appeared to perform more functions than did Wisconsin's DPH. In all of the other states surveyed, the public health agency ran Vital Records and Health Information. Public health agencies in some other states licensed health facilities such as nursing homes and hospitals, ran certificate of need programs, or even operated labs.

In a couple instances, Wisconsin appeared to do more than other states. Some states had their agriculture or commerce departments inspect and license restaurants and other food establishments, and lead and asbestos workers. In Illinois, the WIC and MCH programs are administered by the state's Human Services department.

To the extent practical, we adjusted the information to promote accurate comparisons between the states. In particular, when appropriate, we added Bureau of Health Information into the Wisconsin comparisons of budget and staffing.

By comparison, Wisconsin has a relatively small workforce at both the state and local levels. As Table W shows, Wisconsin ranks 7th among the eight states in the number of public health staff per 100,000 population. This ranking moves to 6th when BHI staff are included. Wisconsin has 9.7 staff per 100,000 population, which is 34 percent below the median 14.85 staff per 100,000 population. Wisconsin ranked 7th among the 8 states for which we were able to obtain information on the number of local public health agency employees. Wisconsin has 42.5 local public health employees per 100,000 population, which is 24 percent below the median of 56 employees. When state and local employees are combined, Wisconsin ranks last among the eight states, with 52.2 staff per 100,000 population (including BHI), or 22 percent below the median of 66.8 employees per 100,000.

We also compared budget resources available in Wisconsin and the seven peer states. Table X-1 shows that on a per capita basis, Wisconsin ranks 7th among the eight states in spending at the state level (all funds considered). Wisconsin spends $35.63 per capita (including BHI), which is 36 percent below the median of peer states. Wisconsin also ranked 6th in local public health per capita spending among the seven states we were able to get data from. When total state and local public health funding per capita is compared, Wisconsin ranks last among the seven states for which data were available. Wisconsin spent $57.73 per capita, which compares with the median of $100.90. If local spending information from Iowa were available and included in the table, Wisconsin would rank 8th among the eight states in combined spending.

This observation is consistent with the statements in the United Health Foundation report, which noted that in 2003, Wisconsin ranked 49th of 50 states in public health spending, or 35 percent below the national average. The Foundation's report states that "Wisconsin's biggest challenge is low support for public health care that is 35 percent below the average state."

In regard to sources of state-level spending, Table X-2 shows that compared to other states, Wisconsin relies on federal funds to a higher degree than do other peer states, and somewhat less on GPR and other funding sources.

Finally, we also reviewed the readily available information on public health outcomes and compared Wisconsin's outcomes to the seven peer states and to the national average. The outcomes we reviewed were highlighted in the recent study by the United Health Foundation. The Foundation's study, which compared the outcomes of all 50 states, focused on the following eight outcomes:

1. Occupational Fatalities, as measured by the number of fatalities from occupational injuries per 100,000 workers. This measure reflects job safety as a part of public health.

2. Limited Activity Days, and measured by the number of days in the previous 30 days when a person indicates their activities are limited due to physical or mental difficulties. This is a general indication of the population's ability to function on a day-to-day basis.

3. Heart Deaths, as measured by the number of deaths due to heart disease per 100,000 population. This is an indication of the toll that heart disease is placing on the population.

4. Cancer Deaths, as measured by the number of deaths due to all causes of cancer per 100,000 population. This is an indication of the toll cancer is placing on the population.

5. Infectious Disease, as measured by the number of AIDS, tuberculosis and hepatitis cases reported to the Centers for Disease Control and Prevention per 100,000 population. This is an indication of the toll that infectious disease is placing on the population.

6. Total Mortality, as measured by the number of deaths per 100,000 population. This is an overall indicator of health of a population as it measures death from all causes.

7. Infant Mortality, as measured by the number of infant deaths (before age 1) per 1,000 live births. This is an indication of the prenatal care, access and birth process for both child and mother.

8. Premature Death, as measured by the number of years of potential life lost prior to age 75 per 100,000 population. This is an indication of the number of useful years of life that are not available to a population due to early death.

A review of these public health outcomes shows that Wisconsin in general is "in the middle of the pack" when compared with the peer states. Given the comparatively smaller commitment of funding and resources in Wisconsin, it could be argued that being "average" in outcomes achieved is a notable a accomplishment. Others might argue, however, that accepting being average is not consistent with the Wisconsin tradition of striving for excellence and high performance in achieving health outcomes. Moreover, as the information below shows, it is worth noting that the Foundation's recent report indicates that Wisconsin's outcomes have eroded when compared with national trends.

Table Y below shows how Wisconsin compares with the 7 peer states in achieving the eight outcomes. For the most recent year, Wisconsin's average ranking was 3.8, with three states having average rankings better than Wisconsin, and three having lower average rankings. (Oregon had the same average ranking.) Ranked well (in second place) on two measures – limited activity days and infectious disease – while the lowest ranking Wisconsin had was 5th place, in occupational fatalities and infant mortality.

As Table Z shows, Wisconsin's average ranking is 17th nationally among the 50 states. In no instance did Wisconsin rank in the bottom half of the states. The Foundation's data, however,

does indicate that Wisconsin's performance based on reviewing the eight outcomes has declined relative to other states. In 1990, Wisconsin's average ranking was 13th and it was ranked in the top 15 for six of the eight outcomes. By 2003, the state's rankings slipped four spots and Wisconsin now ranked among the top 15 states for only two of the eight outcomes. For two outcomes – premature death and infant mortality – the state's rankings declined significantly, with the state's rankings in infant mortality dropping from 8th in 1990 to 23rd in 2003.

Focusing only on rankings may mask some real progress that Wisconsin has made in improving outcomes. As Table Z shows, for six of the eight outcomes, Wisconsin actually experienced improvement in performance. For example, between 1990 and 2003, the rate of infectious diseases and the rate of occupational fatalities declined by 41 percent. However, because other states in general improved even more, Wisconsin experienced an overall decline in rankings. For six of the eight outcomes in which Wisconsin's performance improved, its ranking among the other 50 states actually declined.

Table W:
Comparison of State and Local Public Health Staff Among Eight Peer States
(Per 100,000 State Population)

		-------- State Staff ---------			***-------- LPH Staff ---------***		
State	Population	FTE	Per 100,000 Population		FTE	Per 100,000 Population	Total Per 100,000 Population
Iowa	2,832,392	416	14.7		2,250	79.4	94.1
Minnesota	4,882,303	1,303	26.7		3,094	63.4	90.1
Missouri	5,505,963	1,297	23.6		3,253	59.1	82.6
Washington	5,930,307	1,179	19.9		2,900	48.9	68.8
Illinois	12,279,027	1,104	9.0	*	6,850	55.8	64.8
Michigan	9,797,198	668	6.8	**	5,500	56.1	63.0
Oregon	3,444,153	518	15.0		1,350	39.2	54.2
Wisconsin	5,285,604	440	8.3		2,244	42.5	50.8
Wisconsin (With BHI added)	5,285,604	516	9.8		2,244	42.5	52.2

* Does not include Illinois state-level staff related to the WIC and MCH programs, as these funds and staff are assisgned to to state's human services agency and are not included in the above table.

** Michigan also has 170 staff in its Public Health Institute, which are not counted in the above tally of state level staff. If these staff were included, Michigan's state-level staff per 100,000 would be slightly above Wisconsin's.

NOTE: Data are from the survey of peer states conducted by OPRA in November, 2003. Where possible, information was obtained from websites in the peer states. Most information was collected via a telephone survey and through responses to e-mails seeking specific staffing and funding information.

Table X-1
Comparison of State and Local Public Health Funding Among Eight Peer States

State	Population	State-Level Spending	Spending Per Capita	Local Spending	Spending Per Capita	Combined Spending	Spending Per Capita
Oregon	3,444,153	$ 352,705,444	$ 102.41	$ 154,800,000	$ 44.95	$ 507,505,444	$ 147.35
Minnesota	4,882,303	$ 419,100,000	$ 85.84	$ 276,935,360	$ 56.72	$ 696,035,360	$ 142.56
Washington	5,930,307	$ 317,500,000	$ 53.54	$ 308,000,000	$ 51.94	$ 625,500,000	$ 105.48
Michigan	9,797,198	$ 536,391,700	$ 54.75	$ 452,137,261	$ 46.15	$ 988,528,961	$ 100.90
Missouri	5,505,963	$ 452,189,221	$ 82.13	$ 40,349,114	$ 7.33	$ 492,538,335	$ 89.46
Illinois **	12,279,027	$ 313,091,100	$ 25.50	$ 462,000,000	$ 37.63	$ 775,091,100	$ 63.12
Wisconsin	5,285,604	$ 188,310,900	$ 35.63	$ 116,835,387	$ 22.10	$ 305,146,287	$ 57.73
Iowa *	2,832,392	$ 163,246,843	$ 57.64	UNK	UNK	NA	NA

* Iowa has 98 local public health agencies and has more local public health staff than does Wisconsin on a per capita basis (see Table W). However, Iowa officials report that they do not collect local budget information, so local spending in Iowa is reported here as "Unkonwn."

** Does not include Illinois state-level spending related to the WIC and MCH programs, as these funds are assisgned to the state's human services agency and are not included in the above table. As a point of reference, if the WIC and MCH funds were removed from Wisconsin's total, Illinois would have spent $25.50 per capita at the state level, while Wisconsin would have spent about $22 per capita.

NOTE: Data are from the survey of peer states conducted by OPRA in November, 2003. Where possible, information was obtained from websites in the peer states. Most information was collected via a telephone survey and through responses to e-mails seeking specific staffing and funding information.

Table X-2
Comparison of Sources of Funding for State-Level Spending
Among Eight Peer States

State	State	Percent	Federal	Percent	Other	Percent	Total
Illinois	$ 122,771,000	39%	$ 127,452,100	41%	$ 62,868,000	20%	$ 313,091,100
Minnesota	$ 92,300,000	22%	$ 164,500,000	39%	$ 162,300,000	39%	$ 419,100,000
Washington	$ 67,000,000	21%	$ 145,500,000	46%	$ 105,000,000	33%	$ 317,500,000
Michigan	$ 105,423,300	20%	$ 344,728,900	64%	$ 86,239,500	16%	$ 536,391,700
Wisconsin	$ 34,725,400	18%	$ 126,777,300	67%	$ 26,808,200	14%	$ 188,310,900
Missouri	$ 81,863,107	18%	$ 318,438,264	70%	$ 51,887,850	11%	$ 452,189,221
Iowa	$ 23,906,608	15%	$ 106,761,502	65%	$ 32,578,733	20%	$ 163,246,843
Oregon	$ 28,973,910	8%	$ 265,410,408	75%	$ 58,321,126	17%	$ 352,705,444
Total	$ 556,963,325	20%	$ 1,599,568,474	58%	$ 586,003,409	21%	$ 2,742,535,208

Table Y:
Comparison of Wisconsin to 7 Peer States on Eight Outcomes

Outcomes	Wisconsin	Illinois	Iowa	Michigan	Minnesota	Missouri	Oregon	Washington
Occupational Fatalities	-2	11	26	-11	-28	30	-21	-26
State Rank	***5***	***6***	***7***	***4***	***1***	***8***	***3***	***2***
Limited Activity Days	-20	-20	-30	10	-15	5	10	-5
State Rank	***2***	***2***	***1***	***7***	***4***	***6***	***7***	***5***
Heart Deaths	-9	2	-6	9	-27	11	-21	-18
State Rank	***4***	***6***	***5***	***7***	***1***	***8***	***2***	***3***
Cancer Deaths	0	4	-1	0	-4	5	0	-1
State Rank	***4***	***7***	***2***	***4***	***1***	***8***	***4***	***2***
Infectious Disease	-69	-9	-73	-29	-60	8	-31	-31
State Rank	***2***	***7***	***1***	***6***	***3***	***8***	***4***	***4***
Total Mortality	-4	1	-5	2	-10	7	-2	-6
State Rank	***4***	***6***	***3***	***7***	***1***	***8***	***5***	***2***
Infant Mortality	-1	17	-13	17	-20	6	-20	-20
State Rank	***5***	***7***	***4***	***7***	***1***	***7***	***1***	***1***
Premature Death	-13	3	-16	4	-24	8	-13	-17
State Rank	***4***	***6***	***3***	***7***	***1***	***8***	***4***	***2***
Average State Rank	***3.8***	***5.9***	***3.3***	***6.1***	***1.6***	***7.6***	***3.8***	***2.6***

NOTE: All scores above are expressed as the percent above or below the national average. The more negative the number, the better the performance. State rankings are the based on ranking the eight states in this peer group with each other. The ranking number is in bold and on the right-hand side of the column.

Table Z:
Trends in Wisconsin's Performance in Meeting the United Health Foundation's Eight Outcomes

RANKINGS				*OUTCOMES*	*MEASUREMENT DATA*			
2003	2002	1990	Change in Rankings Since '90		2003	2002	1990	Change Since '90
16	10	14	-2	Occupational Fatalities (Deaths per 100,000 workers)	4.6	4.2	7.8	-41%
7	7	11	4	Limited Activity Days (Days in last 30 days)	1.6	1.6	2.9	-45%
19	18	21	2	Heart Disease (Deaths per 100,000 population)	244.6	250.8	306.3	-20%
24	27	20	-4	Cancer Deaths (Deaths per 100,000 population)	205.7	209.5	195.7	5%
9	4	6	-3	Infectious Disease (Cases per 100,000 population)	8.3	7.4	14.1	-41%
20	20	14	-6	Total Mortality (Deaths per 100,000 population)	841.1	854.5	833.2	1%
23	20	8	-15	Infant Mortality (Deaths per 1,000 live births)	6.8	6.7	8.9	-24%
17	12	7	-10	Premature Death (Years lost per 100,000 population)	6,575	6,623	7,143	-8%
17	15	13	-4	**Average** *(determined by adding ranks and dividing by 8, which is the # of out-come measures).*				

NOTE: Regarding the column "Change in Rankings Since '90," a negative number reflect a decline in the state's ranking. However, in the column "Change Since '90" under the Measurement Data portion of the spreadsheet, a negative number actually reflects an improvement. For example, Wisconsin experienced a 41 percent decline in the rate of infectious diseases in the state from the 1990 measurement until the 2003 measurement. However, because other states in general improved even more, Wisconsin's ranking on this outcome actually declined by 3 spots, from 6th to 9th.

Role of Government in Public Health – State Law Requirements

Statutory Responsibility

The statutory responsibilities for Health, Administration, and Supervision of the Public Health System are found in Wis. Stats. 250. It requires the Secretary to appoint a state health officer. It requires the state health officer to appoint chief medical officers who meet the qualifications under this chapter, and who serve as state epidemiologists to provide public health consultation to, and leadership for, program areas of acute and communicable diseases, occupational and environmental diseases, maternal and child health and chronic diseases. It requires the department to maintain a public health system in cooperation with local health departments; community organizations; and medical clinics that are operated by the governing bodies, or agencies of the governing bodies, of federally recognized American Indian tribes or boards located in this state. It requires the department to serve as the state lead agency for public health; and to assess the health needs in the state based on statewide data collection. It requires the department to establish statewide health objectives and delegate power to local health departments to achieve these objectives and to support local public health service capacity building through grants, consultation and technical assistance. And it requires the department to develop policy and provide leadership in public health throughout the state that fosters local involvement and commitment, that emphasizes public health needs and that advocates for equitable distribution of public health resources and complementary private activities commensurate with public health needs. The department has power to execute what is reasonable and necessary for the prevention and suppression of disease and is designated by statute the state health planning and development agency.

Wis. Stats. 251, specifically s.251.001 Legislative findings, states that the provision of public health services in this state is a matter of statewide concern. Chapter 251 defines the requirements of establishing local health departments, establishing local boards of health and their duties, and defines the levels of service and duties of local health departments. It defines qualifications and duties of local health officers, and requires the department to promulgate rules that specify required services for each of Levels I, II, and III local health departments under this chapter.

Programmatic responsibilities found in **CHAPTER 252 – COMMUNICABLE DISEASES** requires the department to, under:

Powers and duties of department [252.02]
- promulgate rules that specify medical conditions treatable by prescriptions or nonprescription drug products for which pharmacists and pharmacies must report under s.440.142(1), Stats.

Duties of local health officers [252.03]
- take charge if the local authorities fail to enforce the communicable disease statutes and rules.

Immunization Program [252.04]
- carry out a statewide immunization program to eliminate mumps, measles, rubella, diphtheria, pertussis, poliomyelitis and other diseases that the department specifies by rule, and to protect against tetanus;
- provide vaccines without charge, upon request of a school district or local health department, if federal and state funds are available for the vaccine; and provide the necessary professional consultant services to carryout the immunization program;
- prescribe the mechanisms for implementing and monitoring compliance with s.252.04, Stats., and prescribe, by rule, the form that any person immunizing a student shall provide to the student;
- submit annually a report to the legislature under s.13.172(3), Stats., on the success of the statewide immunization program.

Compulsory vaccination during a state of emergency [252.041]
- promulgate rules that specify circumstances, if any, under which vaccination may not be performed on an individual.

Reports of cases [252.05]
- print and distribute, without charge, a chart that provides information about communicable diseases to all local health departments and, upon request, to health care providers and facilities.

Isolation and quarantine [252.06]
- act as the public health authority during the period of the state of emergency and carryout the statutory and rule requirements for isolation and quarantine, if the Governor so designates; or designates the local health department as the public health authority during the period of the state of emergency.

Tuberculosis [252.07]
- identify groups at risk for contracting or transmitting mycobacterium tuberculosis and recommend the protocol for screening members of those groups;
- carryout the requirements specified in statute or promulgated in rule, including making imminent and substantial threat determination regarding an individual who has a confirmed diagnosis of infectious tuberculosis, and order confinement if the requirements are not carried out by the local health officer.

Public health dispensaries [252.10]

- certify a local health department, upon local health department request, to establish and maintain a public health dispensary if the local health department meets the standards established by department rule;
- credit or reimburse each dispensary on an annual or quarterly basis for the operation of public health dispensaries established and maintained in accordance with statutes under this section and rules promulgated by the department;
- purchase drugs necessary for the treatment of mycobacterium tuberculosis from appropriation s.20.435(5)(e), Stats., and dispense to patients through the public health dispensaries, local health departments, physicians or advanced practice nurse prescribes.

Sexually transmitted disease [252.11]

- an officer of the department, or a local health officer, having the knowledge of any reported or reasonably suspected case or contact of a sexually transmitted disease for which no appropriate treatment is being administered, or of an actual contact of a reported case or potential contact of a reasonably suspected case, investigate or cause the case or contact to be investigated as necessary;
- in receiving physician notification, take necessary steps to have a person infected with a sexually transmitted disease and ceases or refuses treatment committed for treatment or observation, or notify the local health officer to take these steps;
- prepare for free distribution upon request to state residents, information and instructions concerning sexually transmitted diseases;
- compile statistics indicating the incidence of gonorrhea, antibiotic resistant gonorrhea, chlamydia and syphilis for each county in the state.

HIV and related infections, including hepatitis C virus infections; services and prevention [252.12]

- distribute funds from the appropriation authorized under this section, and ensure the requirements for distributing funds and confidentiality requirements for the following are met:
  - HIV and related infections, including hepatitis C virus infections; services
  - Partner referral and notification
  - Grants to local projects
  - Statewide public education campaign
  - Information network
  - HIV seroprevalence studies
  - Grants for targeted populations and intervention services
  - Contracts for counseling and laboratory testing services
  - Life care and early intervention services
  - Grant for family resource center
  - HIV prevention grants

Blood tests for HIV [252.13]

- ensures that the state epidemiologist makes separate findings of medical significance and sufficient reliability for a test or a series of tests to detect the presence of HIV, antigen or nonantigenic products of HIV, or an antibody to HIV as required under this authority.

Restrictions on use of a test for HIV [252.15]

- in promulgating department rule, consider all potential routes of transmission of HIV identified by the centers for disease control of the federal public health service.
- for the purpose of this subsection, ensures that the state epidemiologist determines, and/or revises, based on the preponderance of available scientific evidence, or changed available scientific evidence, the procedures necessary in this state to obtain a validated test result and that the Secretary shall declare, and/or declares the revision, under s.250.04(1) or (2)(a), Stats.

Health insurance premium subsidies [252.16]

- subject to the availability of funds in the appropriation under s.20.435(5)(am), distribute funding as authorized under this subsection in each fiscal year to subsidize the premium costs under s.252.17(2), Stats. and under this subsection, the premium costs for health insurance coverage available to an individual who has HIV infection and who is unable to continue his or her employment or must reduce his or her hours because of an illness or medical condition arising from or related to HIV infection; or make full premium payment for the individual's health insurance coverage as authorized under s.252.16(4), Stats.; or pay a portion of the amount of each premium payment for an individual who has a family income as authorized under s.252.16(d), Stats.
- promulgate rules that define family income, establish a procedure for making payments under this subsection, and ensure that payments are actually used to pay premiums for group health plan coverage; and establishes a premium contribution schedule for individuals who have a family income and meets the requirements established under this authority.

Medical leave premium subsidies [252.17]

- establish and administer a program to subsidize, under the appropriation under s.20.435(5)(am), the premium costs for coverage under a group health plan that are paid by an individual who has HIV infection and who is on unpaid medical leave from his or her employment because of an illness or medical condition arising from or related to HIV infections as provided in s.252.16(2);
- subject to the availability of funds in the appropriation under 20.435(5)(am), pay the amount of each premium payment for coverage under the group health plan for an individual who meets the requirements established under this subsection; or pay a portion of the amount of each premium payment for the individual who has a family income;
- promulgate rules that define family income, establish a procedure for making payments under this subsection, and ensure that payments are actually used to pay premiums for group health plan coverage; and establishes a premium contribution schedule for individuals who have a family income and meets the requirements established under this authority.

Regulation of tattooists [252.23]

- provide uniform, statewide licensing and regulation of tattooists and uniform, statewide licensing and regulation of tattoo establishments; inspect a tattoo establishment once before issuing a license for the tattoo establishment, and make additional inspections as deemed necessary by the department;
- promulgate rules for standards and procedures, except as provided in s.250.041 and s.252.241, Stats., including fee payment to offset the cost of licensing tattooists and tattoo establishments, for the annual issuance of licenses tattooists or as tattoo establishments to applicants under this authority.

Regulation of body piercing and body-piercing establishments [252.24]
- provide uniform, statewide licensing and regulation of body piercers and uniform, statewide licensing and regulation of body-piercing establishments, except as provided in s.250.041 and s.252.241, Stats.; inspect a body-piercing establishment once before issuing a license for the body-piercing establishment, and make additional inspections as deemed necessary by the department.
- promulgate rules for standards and procedures, except as provided in s.250.041 and s.252.241, Stats., including fee payment to offset the cost of licensing body piercers or as body-piercing establishments, for the annual issuance of licenses body piercers or as body-piercing establishments to applicants under this authority.

Denial, nonrenewal and revocation of license based on tax delinquency [252.241]
- require the applicant's social security number or applicant's federal employer identification number as a condition of issuing or renewing a license; disclose information to only the Department of Revenue for the sole purpose of requesting certification, and deny applications if the applicant does not meet the requirements defined under this authority.

Agent status for local health departments [252.245]
- reimburse - at the rate of 80% of the net license fee per license per year - the local health department with a jurisdictional area that has a population greater than 5,000 and has been designated by the department as it's agent in issuing licenses to and making investigations or inspections of tattooists and tattoo establishments and body piercers and body-piercing establishments;
- evaluate annually the licensing, investigation and inspection program of each local health department granted agent status;
- provide education and training to agents designated under this authority;
- promulgate rules establishing state fees not to exceed 20% of the license fee established, for costs related to setting standards under s.252.23 and s.252.24, Stats. and monitoring and evaluating the activities of, and providing education and training to, agent local health departments.

Programmatic responsibilities found in **CHAPTER 253 – MATERNAL AND CHILD HEALTH** require the department to, under:

Department; power and duties [253.02]
- maintain a maternal and child health program within the division to promote the reproductive health of individuals and the growth, development, health and safety of infants, children and adolescents and include reproductive health services as defined in s.253.07(1)(b), pregnancy-related services, infant and preschool health services, child and adolescent health services, general maternal and child health services, health services to children with special health care needs, maternal and child health system coordination services that promote coordination of public and private sector activities in these areas of the maternal and child health program;
- designate a subunit within the division to have responsibility for the maternal and child health program and be comprised of an adequate number of interdisciplinary professional staff with expertise in maternal and child health and assume responsibility of planning, coordination, data collection and evaluation of the program, provide consultation and technical assistance to local health professionals, and coordinate program activities with related activities conducted under the authority of other state and federal agencies.

State plan; reports [253.03]
- prepare and submit to the proper federal authorities a plan for maternal and child health services that conforms will all requirements governing federal aid for this purpose and be designated to secure for this state the maximum amount of federal aid which can be secured on the basis of available state, county, and local appropriations; and make such reports, in such form and containing such information, as may be required from time to time by the federal authorities and shall comply with all provisions that may be prescribed to assure correctness and verification of the reports.

Private rights [253.04]
- ensure that no agent or representative of the department enter any home over the objection of the owner or take charge of any child over the objection of the parent or of the person standing in the place of a parent or having custody over the child.

Federal funds [253.05]
- use sufficient funds from the appropriation under s.20.435(1)(a) for the promotion of the welfare and hygiene of maternity and infancy to match federal funds received by the state.

State supplemental food program for women, infants and children [253.06]
- supplement the provision of supplemental foods, nutrition education and other services, including nutritional counseling, to low-income women, infants and children who meet the eligibility criteria under the federal special supplemental food program for women, infants and children authorized under 42 USC 1786, from the appropriation under s.20.435(5)(em);
- consider any relevant conviction of the vendor or any of the vendor's employees for civil or criminal violations substantially related to the operation of a grocery store or pharmacy; and approve or deny initial authorization of vendors application and provide written reasons if the application has been denied;
- redeem valid drafts submitted by a food distribution center;
- promulgate rules to establish minimum qualification standards for the authorization of vendors and for awarding of a contract to an entity under this authority.

Family planning [253.07]
- provide for delivery of family planning services throughout the state by developing and by annually reviewing and updating a state plan for community-based family planning program;
- allocate state and federal family planning funds under its control in a manner which will promote the development and maintenance of an integrated system of community health services and shall maximize the use of existing community family planning services by encouraging local contractual arrangements;
- coordinate the delivery of family planning services by allocating family planning funds in a manner which maximizes coordination between the agencies;
- encourage maximum coordination of family planning services between county social service departments, family planning agencies and local health departments to maximize the use of health, social service and welfare resources;
- promulgate rules necessary to implement and administer this section;
- ensure that individuals rights and medical privileges under this section is adhered to;
- allocate funds from the appropriation under s.20.435(5)(f) as designated under s.253.07(4) for family planning services.

Pregnancy counseling services [253.08]
- make grants from the appropriation under s.20.435(5)(eg) to individuals and organizations to provide pregnancy counseling services and ensure that applicant demonstrates that moneys provided will not be used to engage in any activity specified in s.20.9275(2)(a)1 to 3.

Outreach to low-income pregnant women [253.085]
- conduct an outreach program to make low-income pregnant women aware of the importance of early prenatal and infant health care and availability of medical assistance benefits under subch. IV of ch. 49 and other types of funding for prenatal and infant care services in the community and to make follow-up contacts with women referred to prenatal and infant care services;
- allocate $250,000 for each fiscal year from moneys received under the maternal and child health services block grant, 42 USC 701 to 709, for the outreach program under this section.

Voluntary and informed consent for abortions [253.10]
- provide voluntary and informed consent materials, as specified under this section, that are in a easily comprehensible format and published in English, Spanish, and other languages spoken by a significant number of state residents. Distribute a reasonably adequate number of the materials to county departments as specified in s.46.245 and upon request, and annually review the materials for accuracy, exercising reasonable diligence in providing materials that are accurate and current and meets the requirements set forth under this authority.

Infant Blindness [253.11]
- approve a prophylactic agent for the prevention of ophthalmia neonatorum or infant blindness.

Newborn hearing screening programs [253.115]
- collect annually information from hospitals concerning number of deliveries in each hospital and the availability of newborn hearing screening programs in each hospital; from this information determine the percentage of deliveries in this state performed in hospitals that have newborn screening programs and report this information to legislature under s.13.172(3).

Birth defect prevention and surveillance system [253.12]
- establish and maintain an up-to-date registry that documents and diagnosis in this state of any infant or child who has a birth defect, regardless of the residence of the infant or child and meets the requirements, including consent and confidentiality, under this section.

Tests for congenital disorders [253.13]
- promulgate rules regarding congenital and metabolic disorders blood testing on every infant born in each hospital or maternity home;
- contract with the state laboratory of hygiene to perform the tests specified under this section and to furnish materials for use in the tests;
- provide necessary diagnostic services, special dietary treatment as prescribed by a physician for a patient with a congenital disorder as identified by tests under this section;
- disseminate information to families whose children suffer from congenital disorders and to women of child-bearing age with a history of congenital disorders concerning the need for and availability of follow-up counseling and special dietary treatment and the necessity for infant testing;
- refer families of children who suffer from congenital disorders to available health and family services programs and coordinate the provision of these programs; consult periodically with appropriate experts in reviewing and evaluating the state's infant screening programs.

Sudden infant death syndrome [253.14]
- prepare and distribute printed informational materials relating to sudden infant death syndrome directed toward the concerns of parents of victims and distributed to maximize availability to parents;
- make available upon request follow-up counseling by trained health care professionals for parents and families of victims of sudden infant death syndrome.

Programmatic responsibilities found in **CHAPTER 254 – ENVIRONMENTAL HEALTH** require the department to, under:

Health risk assessments [254.02]
- as lead state agency for health risk assessment, enter into a memorandum of understanding with other state agencies identified under this section to establish protocols for the department to review proposed rules of those state agencies relating to air and water quality, occupational health and safety, institutional sanitation, toxic substances, indoor air quality, food protection or waste handling and disposal;
- review proposed rules in the areas under this section and make recommendations to the appropriate state agency if public health would be adversely impacted or if prevention and human health hazards or disease is not adequately addressed by the proposed rules; and make recommendations for enforcement standards to address public health concerns of the proposed rules;
- enter into a memorandum of understanding with the state laboratory of hygiene that delineates the public health testing and consultative support that the state laboratory of hygiene shall provide to local health departments;
- assess the acute or chronic health effect from occupational or environmental human health hazards through a system (established by the chief medical officer for environmental health) for assessment, collection and surveillance of disease outcome and toxic exposure data; and by investigating human health implications – as reported by other state agencies and local health departments - of an incident and determine the need to perform a health risk assessment
- enter into a memorandum of understanding with state agencies that require health risk assessment as part of their permit issuance or regulatory responsibilities that permits the state health officer to establish a risk management protocol to review and make recommendations on the completeness of health risk assessments.

Toxic Substances – Subchapter II
Denial, nonrenewal and revocation of certification and permit based on tax delinquency [254.115]
- oversee application, renewal and denial process of certification, certification card or permit for possession of toxic substances, and ensuring that confidentiality requirements are met.

Reporting requirements [254.13]
- promulgate rules for reporting results of lead poisoning or lead screening, and specifying the form of the reports required under this subsection.

Departmental duties [254.15]
- develop and implement a comprehensive statewide lead poisoning or lead exposure prevention and treatment program that includes:
  - lead poisoning or lead exposure prevention grants under s.254.151;
  - promulgate rules for awarding grants, childhood lead screening requirements; requirements regarding care coordination and follow-up for children with lead poisoning or lead exposure; lead investigation requirements; lead inspection requirements; any lead hazard reduction requirements; certification, accreditation and approval requirements; and any fees imposed under this section;
- provide laboratory testing of biological and environmental lead specimens for lead content to any physician, hospital, clinic, municipality or private organization that cannot secure or provide testing through other sources;
- develop and encourage the development of appropriate programs and studies to identify sources of lead poisoning or lead exposure, and assist other entities in the identification of lead in children's blood and the other sources of lead poisoning or lead exposure;

- provide technical assistance and consultation to local, county or regional governmental or private agencies to promote and develop lead poisoning or lead exposure prevention programs that afford opportunities for employing residents of communities and neighborhoods affected by lead poisoning or lead exposure, and provide appropriate training, education and information to these residents;
- provide recommendations for the identification and treatment of lead poisoning or lead exposure; develop educational programs to communicate the danger of lead poisoning or lead exposure from lead-bearing paint among children.

Lead poisoning or lead exposure prevention grants [254.151]

- award grants from the appropriation under s.20.435(5)(ef), which meet the requirements established under this section or in rules promulgated under this section.

Delegation to local health departments [254.152]

- except with respect to the department's authority to promulgate rules under this chapter, designate and provide sufficient funds to a local health department to carry out any responsibilities as an agent designated under this section.

Definition of lead-bearing paint and lead poisoning or lead exposure [254.156]

- promulgate rules defining "lead-bearing paint" or "lead poisoning" exposure to correspond to the specification of the centers for disease control and prevention.

Departmental response to reports of lead poisoning or lead exposure [254.166]

- conduct and report a lead investigation of the dwelling or premises or ensure that a lead investigation is conducted as required under this section;
- give priority to eliminating lead hazards from dwellings in which children under 6 years of age with diagnosed lead poisoning or lead exposure reside.

Technical advisory committee [254.174]

- appoint a technical advisory committee under s.227.13 and consult with the technical advisory committee on proposed rules and their promulgation under s.254.167, s.254.168, s.254.172 or s.254.179.

Accreditation of lead training courses and approval of lead instructors [254.178]

- promulgate rules establishing requirements, except as provided in s.250.041, for accreditation of lead training courses and approval of lead instructors, including requirements and procedures for granting, renewing, revoking and suspending, and specify fees under this section for lead training course accreditation and lead instructor approvals;
- maintain and make available to the public lists of all lead training courses accredited, and all lead instructors approved under this section.

Rules for dwellings and premises [254.179]

- subject to s.254.174 and after review of ordinances of cities, towns and villages in this state, promulgate as rules - by use of a research-based methodology - standards for a premises, dwelling or unit of a dwelling that must be met for issuance of a certificate of lead-free status or a certificate of lead-safe status. Procedures by which a certificate of lead-free status or a certificate of lead-safe status may be issued or revoked; the period of validity of a certificate of lead-free status or a certificate of lead-safe status to include the requirements under s.254.179(c). A mechanism for creating a registry of all premises, dwellings or units of dwellings for which a certificate of lead-free status or a certificate of lead-safe status is issued. The requirements for a course of up to 16 hours that a property owner or his or her employee or

agency may complete in order to receive certification of completion and the scope of the lead investigation and lead hazard reduction activities, to the extent consistent with federal law;
- review the rules under this section and promulgate changes to the rules if necessary in order to maintain consistency with federal law;
- review the fees, if imposed, every 2 years and adjust the fees to reflect the actual costs.
- notify a local health department, at least quarterly, concerning issuance of certificates of lead-free status and certificates of lead-safe status in the area jurisdiction of the local health department;

Asbestos abatement certification [254.20]
- establish, except as provided in s.250.041, the procedure for issuing certification cards under this subsection; prescribe an application form and establish an examination procedure, and charge fees as established under this authority.

Asbestos management [254.21]
- promulgate rules to:
  - establish building inspection requirements and procedures to protect students and employees from asbestos hazards in schools;
  - regulate asbestos abatement activities in schools;
  - establish requirements for the maintenance of asbestos-containing material is schools which contain asbestos-containing material;
  - establish priorities for asbestos abatement activities in schools which contain asbestos-containing materials;
  - require a management plan for asbestos-containing material in every school which contains asbestos-containing material.

Indoor air quality [254.22]
- investigate illness and disease outbreaks suspected of being caused by poor indoor air quality; promote and require control measures if indoor air quality is established to be the cause of illness or disease outbreaks;
- assist local health departments in adopting regulations that establish standards for indoor air quality in public buildings to protect the occupants from adverse health effects due to exposure to chemical or biological contaminants.
- provide training and technical support to local health departments for conducting indoor air quality testing and investigations;
- assist the department of commerce wit the enforcement of s.101.123.

Radiation Protection – Subchapter III
Public policy [254.33]
- advise, consult, and cooperate with other agencies of the state, the federal government, other states and interstate agencies and with affected groups, political subdivisions and industries; and, in general, to conform as nearly as possible to nationally accepted standards in the promulgation and enforcement of rules regarding radiation and their sources.

Powers and duties [254.34]
- promulgate and enforce rules, including registration and licensing of sources of ionizing radiation, as may be necessary, to prohibit and prevent unnecessary radiation exposure;
- administer requirements under this subchapter and the rules promulgated under this subchapter;

- develop comprehensive policies and programs for the evaluation, determination and reduction of hazards associated with the use of radiation that are compatible with requirements of the U.S. nuclear regulatory commission; and maintain files as required under this subsection;
- encourage, participate in or conduct studies, investigations, training, research and demonstrations relating to the control of radiation hazards, the measurement of radiation, the effects on health of exposure to radiation and related problems as it deems necessary or advisable for the discharge of its duties under this subchapter;
- collect and disseminate health education information relating to radiation protection as it deems proper;
- review and approve plans and specifications for radiation sources submitted pursuant to rules promulgated under this subchapter, and inspect radiation sources, their shielding and immediate surroundings and records concerning their operation;
- develop and disseminate current radon information; coordinate a program of measuring radon gas accumulation; work with local health department staff to perform home surveys and diagnostic measurements and develop mitigation strategies; develop material and conduct trainings; develop standards of performance for the regional radon centers.

Registration of ionizing radiation installations [254.35]
- oversee the application, amended applications, and applicable fees associated with registration of ionizing radiation installations as required under this subchapter.

Licensing of radioactive material [254.365]
- oversee the issuance, modification, or termination of license under this subsection;
- promulgate rules for issuance modification, suspension, termination and revocation of specific licenses, and requirements for a general license, as required under this subsection.

Enforcement [254.37]
- upon inspection and examination, enforce notification of violation and order of abatement as required under this subchapter;
- promulgate and enforce rules pertaining to ionizing radiation.

Radiation monitoring of nuclear power plants [254.41]
- Conduct environmental sampling and oversee annual fee requirement of each nuclear power plant in the state.

Penalties [254.45]
- send notice of forfeiture for a particular violation as determined by the department, and remit to the secretary of administration for deposit in the school fund.

Recreational Sanitation – Subchapter IV
Beaches [254.46]
- close or restrict swimming, diving and recreational bathing if a human health hazard exists in any area used for those purposes on a body of water and on associated land and shall require the posting of the area, unless this requirement is being met by the local health department.

Recreational permits and fees [254.47]
- issue permits to and regulate campgrounds and camping resorts, recreational and educational camps and public swimming pool, unless this requirement is being met by a local health department granted agent status under s.254.69(2);
- preinspect before granting a permit to a person intending to operate a new public swimming pool, campground, or recreational or educational camp, or to a new operator of an existing

public swimming pool, campground, or recreational or educational camp, unless this requirement is being met by a local health department granted agent status;
- promulgate rules, except as provided in s.254.69(2)(d) and (e), that establish, for permits issued under this section, amounts of permit fees, preinspection fees, reinspection fees, fees for operating without a license, and late fees for untimely permit renewal, except as established by the local health department granted agent status who has not contracted with the department to provide this service, or state fees established by the department for monitoring and evaluating activities and providing education and training to agent local health departments.

Animal-Borne and Vector-borne Disease Control – Subchapter V
Powers and duties [254.51]
- as provided by the state epidemiologist of communicable disease, take measures that are necessary for the prevention, surveillance and control of human disease outbreaks associated with animal-borne and vector-borne transmission;
- enter into memoranda of understanding with the department of agriculture, trade and consumer protection, the department of commerce and the department of natural resources regarding the investigation and control of animal-borne and vector-borne disease;
- promulgate rules that establish measures for prevention, surveillance and control of human disease that is associated with animal-borne and vector-borne disease transmission.

Lyme disease; treatment, information and research [254.52]
- perform research relating to Lyme disease in humans;
- consult with the department of public instruction, the department of natural resources and the department of agriculture, trade and consumer protection, to:
  - monitor the spread, and investigate suspected confirmed cases, of Lyme disease;
  - review materials, activities and epidemiologic investigations prepared or conducted in other states in which Lyme disease is endemic and recommend a statewide strategy;
  - develop, update and disseminate information, as required under this section, for use by clinicians, laboratory technicians and local health departments that diagnose or treat Lyme disease or investigate cases or suspected cases of Lyme disease; and through offices of physicians, public presentations and other releases of information;
- conduct research on the serological prevalence of Lyme disease.

Lodging and Food Protection – Subchapter VII
Coordination; certification [254.62]
- enter into a memoranda of understanding with other state agencies to establish food protection measures;
- promulgate rules that establish a food sanitation manager certification program

Preinspection [254.65]
- preinspect before granting a permit to a person intending to operate a new hotel, tourist rooming house, bed and breakfast establishment, restaurant or vending machine commissary or to a person intending to be the new operator of an existing hotel, tourist rooming house, bed and breakfast establishment, restaurant or vending machine commissary, unless this requirement is being met by a local health department granted agent status;
- make a number of inspections, annually, of restaurants in this state that equal the number of restaurants for which annual permits are issued under s.254.64(1)(a), unless this requirement is met by a local health department granted agent status.

Fees [254.68]

- promulgate rules that establish, for permits issued under s.254.64, permit fees, preinspection fees, reinspection fees, fees for operating without a permit, late fees for untimely permit renewal, fees for comparable compliance or variance requests, and fees for pre-permit review of restaurant plans, except as established by the local health department granted agent status who has not contracted with the department to provide this service, or state fees established by the department for monitoring and evaluating activities and providing education and training to agent local health departments.

Agent status for local health departments [254.69]

- reimburse local health departments, designated and furnishing services, at the rate of 80% of the net license fee per license per year issued in the jurisdictional area.
- coordinate the designation of agents under this subsection with the department of agriculture, trade and consumer protection to ensure, to the extent feasible, the same local health department is granted agent status under this subsection and under s.97.41.
- evaluate, annually, the licensing, investigation and inspection program of each local health department granted agent status;
- provide education and training to agents designated under this subsection to ensure uniformity in the enforcement of this subchapter, s.254.47 and rules promulgated under this subchapter and s.254.47
- establish state fees for its costs related to setting standards under this subchapter and s.254.47 and monitoring and evaluating the activities of, and providing education and training to, agent local health departments;
- in response to an emergency, inspects establishments in jurisdictional areas of local health departments where agent status is granted for the purpose of monitoring and evaluating the local health department's licensing, inspection and enforcement program or at the request of the local health department;
- hold hearings under ch. 227 if interested person, in lieu of proceeding under ch. 68, appeals to the department alleging that a permit fee established by the local health department granted agent status exceeds the reasonable costs described under this subsection, or the person issuing, refusing to issue, suspending or revoking a permit or making an investigation or inspection of the appellant has a financial interest in a regulated establishment which may interfere with his or her ability to properly take that action.

Certificate of food protection practices [254.71]

- conduct evaluations of the effect that the food protection practices certification program has on compliance by restaurants with requirements established under s.254.74(1);
- promulgate rules concerning establishing a fee for certification and recertification of food protection practices; specifying standards for approval of training courses for recertification of food protection practices; and establishing procedures for issuance, except as provided in s.250.041, of certificates of food protection practices, including application submittal and review.

Powers and duties of the department and local health departments [254.74]

- administer and enforce this subchapter, the rules promulgated under this subchapter and any other rules or laws relating to the public health safety in hotels, tourist rooming houses, bed and breakfast establishments, restaurants, vending machine commissaries, vending machines and vending machine locations;
- require hotels, tourist rooming houses, restaurants, vending machine commissaries to file reports and information the department deems necessary;
- ascertain and prescribe what alterations, improvements or other means or methods are necessary to protect the public health safety on those premises;

- prescribe rules and fix standards as authorized under this subsection, including rules covering the general sanitation and cleanliness of premises regulated under this subchapter, the proper handling and storing of food on such premises, the construction and sanitary condition of the premises and equipment to be used and the location and servicing of equipment;
- hold hearings under ch. 227 if interested person, in lieu of proceeding under ch. 68, appeals to the department alleging that a permit fee for a hotel, restaurant, temporary restaurant, tourist rooming house, campground, camping resort, recreational or educational camp or public swimming pool exceeds the permit issuer's reasonable costs of issuing permits to, making investigations and inspections of, and providing education, training and technical assistance to the establishment.

Enforcement [254.85]
- pay, or offer to pay, the market value if samples of food are taken; examine the samples and specimens secured, conduct other inspections and examinations needed to determine whether there is a violation of this subchapter, s.254.47, or rules promulgated by the department under this subchapter or s.254.47;
- promptly notify owner or custodian of the food or premises upon completed analysis and examination, determines that the food, construction, sanitary condition, operation or method of operation of the premises or equipment does not constitute an immediate danger to health. Until then, no food described in a temporary order issued and delivered may be sold or moved, and no operation or method of operation prohibited by the temporary order may be resumed without the approval of the department.

Court review [254.87]
- orders of the department shall be subject to review in the manner provided ch. 227.

Sale or Gift of Cigarettes or Tobacco Products to Minors – Subchapter IX
Investigations [254.916]
- in consultation with other governmental regulatory authorities and with retailers, establish standards for procedures and training for conducting investigations under this section;
- compile results of investigations performed under this section and prepare an annual report that reflects the results for submission with the state's application for federal funds under 42 USC 300x-21;
- strive to annually negotiate with the federal department of health and human services realistic and attainable interim performance targets for compliance with 42 USC 300x-26;
- provide education and training to governmental regulatory authorities to ensure uniformity in the enforcement of this subchapter;
- in response to an emergency, investigate establishments in jurisdictional areas of local health departments where agent status is granted for the purpose of monitoring and evaluating the governmental regulatory authority's investigation and enforcement program or at the request of the governmental regulatory authority.

Programmatic responsibilities found in **CHAPTER 255 – CHRONIC DISEASE AND INJURIES** require the department to, under:

Chronic Disease Prevention, Assessment and Control

Duties of the state epidemiologist for chronic disease [255.02]

- As provided by the state epidemiologist for chronic disease:
  - develop and maintain a system for detecting and monitoring chronic diseases within this state;
  - investigate and determine the epidemiology of those conditions that contribute to preventable or premature illness, disability and death.

Duties of the department [255.03]

- conduct programs to prevent, delay and detect the onset of chronic diseases, including cancer, diabetes, cardiovascular and pulmonary disease, cerebrovascular disease and genetic disease, and other chronic diseases that the department determines are important to prevent, delay and detect in order to promote, protect and maintain the public's health;
- establish programs of community and professional education relevant to the detection, prevention and control of chronic diseases;
- assist local health departments in performing activities related to chronic disease, including risk assessment, monitoring, surveillance and education.

Cancer reporting [255.04]

- prescribe the form on which to report; time schedule under which the report shall be submitted; type of cancer and precancerous conditions to be reported;
- follow confidentiality guidelines as required under s.255.04(3);
- allocate funds from the appropriation under s.20.435(5)(cc) in each fiscal year to provide grants to applying individuals, institutions or organizations for the conduct of projects on cancer control and prevention;
- promulgate rules establishing the criteria and procedures for the awarding of grants for cancer control and prevention projects.

Well-woman program [255.06]

- administer a well-woman program to provide reimbursement for health care screenings, referrals, follow-ups, and patient education provided to low-income, underinsured, and uninsured women; ensure reimbursement to service providers under this section do not exceed the rate provided under medicare; and modify services or reimbursement if projected costs under this section exceed the amounts appropriated under s.20.435(5)(cb);
- implement, within this limitation, the well-woman program and provide breast cancer screening services; media announcements and educational materials; breast cancer screenings using mobile mammography van; specialized training for rural colposcopic examinations and activities; health care screening, referral, follow-up and patient education; women's health campaign; osteoporosis prevention and education; multiple sclerosis education and services; and service coordination following all requirements under s.255.06 (a) through s.255.06(3).

Tanning facilities [255.08]

- enforce as required under this section.

Thomas T. Melvin youth tobacco prevention and education program [255.10]

- administer the youth tobacco prevention and education program, with the primary purpose of reducing the use of cigarettes and tobacco products by minors, from the moneys distributed under s.255.15(3)(b); award grants for the purposes of community education provided through local community initiatives; a multimedia education campaign directed at encouraging minors

not to begin using tobacco, motivating and assisting adults to stop using tobacco and changing public opinion on the use of tobacco; public education through grants to schools to expand and implement curricula on tobacco education; research on methods by which to discourage use of tobacco; and evaluate the program under this section.

Statewide tobacco use control program [255.15]
- administer the grant program from the appropriation under s.20.435(5)(fm);
- promulgate rules establishing criteria for recipients of grants awarded under s.20.435(5)(fm), including performance-based standards for grant recipients that propose to use the grant for media efforts; ensure that programs or projects conducted under the grants are culturally sensitive;
- provide a forum for the discussion, development, and recommendation of public policy alternatives in the field of smoking cessation and prevention;
- provide a clearinghouse of information on matters relating to tobacco issues and how they are being met in different places throughout the nation such that both lay and professional groups in the field of government, health care and education may have additional avenues for sharing experiences and interchanging ideas in the formulation of public policy on tobacco;
- continue implementation of a strategic plan for a statewide tobacco use control program, including the allocation of funding, and update the plan annually;
- reports to the governor and to the chief clerk of each house of the legislature for distribution under s.13.172(2) a report that evaluates the success of the grant program under s.255.15(3) annually, and meets the reporting requirements under s.255.15(4) and (5).

Injury Prevention and Control – Subchapter III
Duties of the department [255.20]
- maintain an injury prevention program that includes data collection, surveillance, education and the promotion of intervention;
- assist the local health departments and community agencies by serving as a focal point for injury prevention expertise and guidance and by providing the leadership for effective local program development and evaluation;
- enter into a memoranda of understanding with other state agencies to reduce intentional and unintentional injuries.

Programmatic responsibilities found in **CHAPTER 146 – MISCELLANEOUS HEALTH PROVISIONS** require the department to, under:

Minority health [146.185]
- identify barriers to health care, conduct statewide hearings on issues of concern, review, monitor and advise all state agencies with respect to impact on the health of economically disadvantaged minority group members;
- work closely with state agencies, including the board of regents of the University of Wisconsin System and the technical college system board, with the University of Wisconsin Hospitals and Clinics Authority, and private sector and with groups concerned with issues of health, of economically disadvantaged minority group members to develop long-term solutions to health problems;
- develop and disseminate materials that are culturally sensitive and appropriate and that promote health care professions as careers;
- submit a biennial report to the governor and appropriate standing committees under s.13.172(3) on the activities of the department under this section, including recommendations on program policies, procedures, practices and services affecting the health status of economically disadvantaged minority group members;

- award grants annually from the appropriation under s.20.435(5)(kb) for activities to improve the health status of the economically disadvantaged minority group members.

Cooperative American Indian Health projects [146.19]
- award grants, as authorized under this section, from the appropriation s.20.435(5)(ke) for cooperative American Indian health projects in order to promote cooperation among tribes, tribal agencies, inter-tribal organizations and other agencies in addressing specific problem areas in the field of American Indian health.

Emergency medical services personnel; licensure; certification; training [146.50]
Licensing of Ambulance Service Providers and Emergency Medical Technicians; Training; Permits:
- license, except as provided in s.146.51 and 146.52, qualified applicants as ambulance service providers or emergency medical technicians and establish the primary service or contract area of the ambulance service provider;
- promulgate rules establishing a system and qualifications for issuance of training permits, except as provided in s.146.51 and 146.52, specifying the period for which an individual may hold a training permit.

Qualifications for Licensure:
- promulgate rules in conjunction with the technical college system board, specifying training, education, or examination requirements, to include training for response to acts of terrorism and license renewals for emergency medical technicians;

- certify qualified applicants, except as provided in s.146.51 and 146.52, for the performance of defibrillation under certification standards the department promulgates in rule.

Certification of First Responder:
- certify, except as provided under s.146.51 and 146.52, applicants who meet the qualifications for first responders under this section;
- review training courses for the use of a semiautomatic defibrillator under this section and that satisfy standards for approval that are specified by the department;

Qualifications for Medical Directors:
- promulgate rules that set forth qualifications for medical directors;
- approve emergency medical technician – basic training course for treatment of anaphylactic shock and determine and arrange for training in an area or community where need exists.

License Renewal:
- renew licenses applied for under this section unless the department finds that the applicant has acted in a manner or under circumstances constituting grounds for suspension or revocation of the license.

Unlicensed or Uncertified Operation:
- meeting all requirements provided by law, promulgate rules that specify actions under this section, including rules that specify actions that emergency medial technicians may undertake and the required involvement of physicians in actions undertaken by emergency medical technicians.

Denial, nonrenewal and suspension of license, training permit or certification based on certain delinquency in payment [146.51(1)]
- meeting all requirements provided under law, including confidentiality, deny an application for the issuance or renewal of a license, training permit or certification, or suspend a license, training permit or certification if the holder does not provide the required documentation; or

under a memorandum of understanding [s.49.857(2)] restrict a license training permit or certification if the department of workforce development certifies that the holder is delinquent in the payment of court-ordered payments of child-support, maintenance, birth expenses, medical expenses or other expenses related to the support of a child or former spouse or fails to comply after appropriate notice.

Denial, nonrenewal and revocation of license, certification or permit based on tax delinquency [146.52]

- meeting all requirements provided under law, including confidentiality, deny an application for the issuance or renewal of a license, certificate or permit, or revoke a license, certificate or permit if the department of revenue certifies under [s.73.0301] that the applicant for or holder of the license, certificate or permit is liable for delinquent taxes.

State emergency medical services activities [146.53]

- prepare plan by reviewing all statutes and rules that relate to emergency medical services and recommend in the plan any changes in those statutes and rules that the department considers appropriate; include an identification of priorities for changes in the state emergency medical services system for the two years following preparation of the plan; maintain the plan based on changes in the state emergency medical services system and based on determinations of the board.
- Provide copies of the state emergency medical services plan biennially to the legislature under s.13.172(2);
- consult with the board before promulgating a proposed rule that relates to funding of emergency medical services programs or to regulation of emergency medical services
- serve as lead state agency for emergency medical services:
  - implement measures to achieve objectives that are set forth in the state emergency medical services plan;
  - provide quality assurance in the emergency medical services system, including collecting and analyzing data related to local and regional emergency medical services systems;
  - provide technical assistance in developing plans, expanding services and complying with applicable statutes and rules;
  - set standards for all organizations that offer training – both initial and continued training;
  - facilitate integration of service providers and hospitals in the same geographic area;
  - review recommendation by the board;
  - investigate complaints;
  - provide advice to adjutant general and coordinate emergency activities with the department of military affairs;
  - consult as least annually with the technical college system board and the department of transportation on issues that affect ambulance service providers, first responders and emergency medical services;
  - promulgate rules that set forth the authority and duties of medical directors and the state medical director for emergency medical services.

Emergency medical services programs [146.55]

- provide administrative support and technical assistance to emergency medical services programs; coordinate activities of agencies and organizations providing training for delivery of emergency medical services; assist the development of training; assess the emergency medical services resources and encourage allocation of resources to areas of identified need;
- contract with a physician to direct the state emergency medical services program.

Support and Improvement of Ambulance Services:
- distribute annually, funds from the appropriation under s.20.435(5)(ch) for the provision of vehicles, supplies and equipment, or emergency medical training as authorized under s.146.55(4);

Emergency Medical Technician Training and Examination Aid:
- distribute annually, funds from the appropriation under s.20.435(5)(ch) to entities, including technical college districts whose courses or instructional programs are approved by the department under s.146.50(9); to assist the entities in providing the training required for licensure or licensure renewal under s.146.50(6); to administer examinations by an entity for licensure or licensure renewal under s.146.50(6)(a)3 and (b)1.

Statewide trauma care system [146.56]
- develop and implement a statewide trauma care system, seeking advice of the statewide trauma advisory council under s.15.197(25) in developing and implementing the system, and as part of the system, develop regional trauma advisory councils;
- promulgate rules to develop and implement the system; rules to include a method to classify all hospitals as to their respective emergency care capabilities and based on standards developed by the American College of Surgeons.

Statewide poison control system [146.57]
- implement a statewide poison control system, which provides poison control services (poison information and education) statewide and that are available on a 24-hour per day and 365-day per year basis;
- distribute funds from the appropriation under 20.435(5)(ds) if requirements under this section are met;
- promulgate rules that specify the information that shall be reported to the department under the statewide poison control program.

Contents of certain patient health care records [146.815]
- provide forms and guidelines, which meet statutory requirements, for determining whether to prepare the patient health care record.

Confidentiality of patient health care records [146.82]
- the release of a patient health care record information under this subdivision shall be limited to the information prescribed by the department under s.255.04(2).

Access to patient health care records [146.83]
- prescribe by rule fees that are based on an approximation of actual costs, plus applicable tax and postage or delivery, that a health care provider can charge for the duplication of patient health care records, and for duplicate X-ray reports or referral of X-rays to another health care provider of the patient's choice.

Programmatic responsibilities found in **CHAPTER 160 – GROUNDWATER PROTECTIONS STANDARDS** require the department to, under:

Establishment of enforcement standards; substances of pubic health concern [160.07]
- enter into a memorandum of understanding with the department of natural resources setting forth the procedures and responsibilities of each agency in establishing enforcement standards under this section;

- recommend enforcement standard for each substance submitted which is designated as a public health concern and evaluating the evidence for establishing an enforcement considering the extent to which the evidence was developed.

Public information [160.11]
- assist the department of natural resources in promulgating any enforcement standards as rules and responding at the public hearing to all questions previously submitted in writing.

Methodology to establish enforcement standard [160.13]
- establish a recommended enforcement standard for a substance, determine the acceptable daily intake, and evaluate evidence for establishing an acceptable daily intake value as required and defined under this section.

Programmatic responsibilities found in **Chapter 46 – SOCIAL SERVICES** require the department to, under:

Services to homeless individuals [46.972]
- allocate, in each fiscal year, up to $125,000 from the appropriate under s.20.435(5)(ce) to applying public or nonprofit private entities for the costs of providing primary health services and any other services that may be funded by the program under 42 USC 256 to homeless individuals.

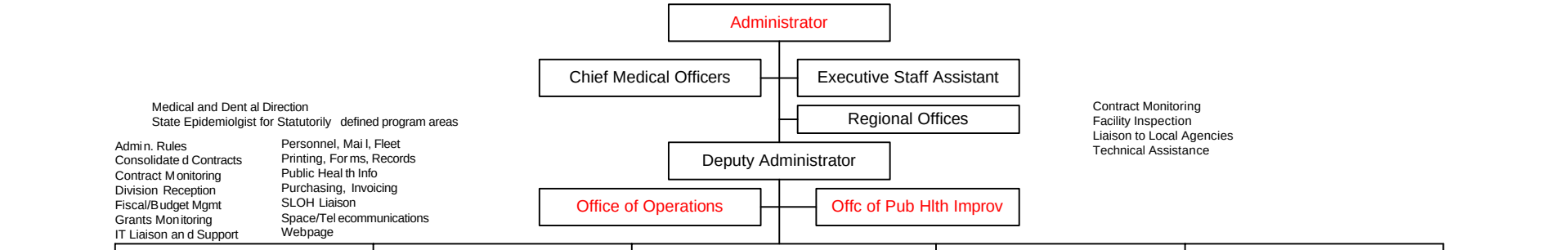
Prepared by Margaret Taylor
Division of Public Health
January 14, 2004

Department of Health and Family Services

Division of Public Health

Functions

Published: September 2003



Bureau of Environmental Hlth

Environmental Sanitation
- Food Manager Cert.
- Hotel/Restaurant Lic.
- Milk Certification
- Sanitarian Registration
- Tattoo/BP Lic.

Epidemiology & Toxicology
- Ambient Air Quality
- Asthma Intervention
- Cluster Investigation
- Environmental Epidemiology
- Great Lakes Fish Consumption
- Groundwater Standards
- Toxicology

Health Hazard Evaluation
- Childhood Lead Prev.
- Environ. Disease Invest.
- Hazard Education
- Hlth Hazards Invest
- Indoor Air Quality Invest.
- Superfund Site Assess.

Radiation Protection
- Emerg. Response
- NRC Agreement State
- Radioactivity Monitoring
- Radon Prevention
- Tanning Bed Lic.
- X-Ray Registration

Bureau of Occupational Hlth

- ABLES
- FACE
- OSHA Lab
- Repro. Haz. Workplace
- Youth Occupational Injury

Asbestos and Lead
- Asbestos Abatement Certification
- Asbestos Abatement Notification
- Asbestos Compliance/ Enforcement
- Asbestos Course Accreditation
- Asbestos Education/Outreach
- Asbestos in Schools
- Asbestos Investigation Certification
- Asbestos Trainer Staff Approvals
- Lead (Pb) Abatement Certification
- Lead (Pb) Abatement Notification
- Lead (Pb) Certification Exam Admin.
- Lead (Pb) Compliance/ Enforcement
- Lead (Pb) Course Accreditation
- Lead (Pb) Education/Outreach
- Lead (Pb) Investigation Certification
- Lead (Pb) Property Registry
- Lead (Pb) Trainer Staff Approvals

OSHA Consultation
- Consultation
- Safety & Hlth Prog Mgmt
- Training

Bureau of Family & Community Hlth

Family Health
- Adolescent Health
- Birth Defects and Surveillance
- Children with Special Health Care Needs
- Congenital Disorders
- Genetics
- Health Education and Systems
- Infant/Young Child Health
- Maternal/Perinatal Health
- Oral Health
- Preconceptional/Reproductive Health
- Universal Newborn Hearing

Nutrition
- Breastfeeding
- Nutrition
- WIC
- WIC Farmers Market Nutrition Program

WIC Vendor
- Participant Fraud and Abuse
- Vendor Fraud and Abuse
- WIC Vendor Authorization

Bureau of Emergency Medical Svcs & Injury Prevention

EMS System & Lic
- Ambulance Prov Lic
- Basic/Adv Life Supp
- Comm System
- Data Collection
- EMT Licensing
- First Responder/Defib Cert
- Funding Assist Prog
- Licensing Exams
- Paramedic Lic
- Quality Assurance
- Surveillance
- Training Approval
- Trauma

Injury Prevention
- EMS for Children
- Emergency Response
- Injury Epi & Consult
- Sexual Assault Prev

Bureau of Chronic Disease Prevention and Health Promotion

Chronic Disease
- Breast & Cerv Cancer
- Cardiovasc Hlth
- Diabetes Control
- Prostate Cancer
- Tobacco Control

Primary Care/Hlth Promo
- Comp School Hlth Pro
- Coop Amer Indian Hlth
- HFS 140 Review
- Health Promotion
- Homeless
- J-1 Visa, NHSC
- Marquette Dental
- Minority Health
- Organ Donor Procurement
- P H Nursing
- P H Reporting System
- PHHS Block Grant
- Physical Activity
- Primary Care
- Rural Health, HPSA
- Turning Point
- Women's Health

Bureau of Communicable Diseases

AIDS/HIV
- Case Management
- Counseling and Testing
- Drug Reimbursement
- Early Intervention
- HEPC Surveillance
- HIV Prevention
- Insurance Continuation
- Partner Referral
- Ryan White

Communicable Disease Epidemiology
- Disease Surveillance
- Emerg Path Cons
- Food/H20 Outbreaks
- Hep
- Influenza Surv
- Outbreak Investigation
- Refugee Health
- SLOH Liaison
- TB Consult
- TB Dispensary
- Vectorborne Surv

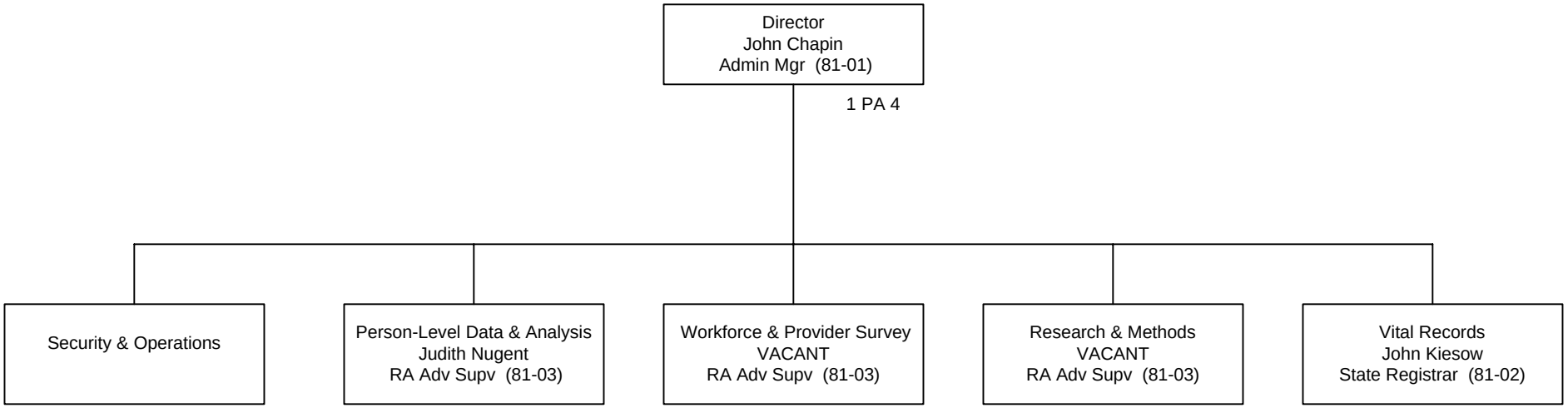
Immunization
- Contract Monitoring
- Disease Surveillance
- Hep B
- Provider Education
- Vaccine Purchase
- VFC
- WIR

Sexually Transmitted Disease
- Consultation
- Partner Notification
- Prevention
- Surveillance
- Technical Assistance

Total Positions: 398

Department of Health and Family Services
Division of Health Care Financing
Bureau of Health Information (BHI)

January 2004



1 PA 2
1 IS Tech Serv Spec-Sr
1 PHE-Adv
1 RA 5
1 Accountant Sr
1 BPA Div
1 Fin Spec 2
2 IS Resource Sup Tech Sr

3 PA 3
1 IS Comp Serv Spec
4 RA 6
3 RA 5
3 RA 4
2 RT 3
1 RT 4
1 RT 2

1 PA 3
2 RA 6
5 RA 4
1 RA 2
1 RT 3
1 RT 2

1 PA 3
2 RA 7
7 RA 6
1 RA 4

1 RA 6
2 Vital Rec Prog Spec
1 PA 3

Registration and Statistics
1 Vital Rec Prog Supv
1 ISBA Sr
1 RT 3
2 Coding Tech
1 PA 3
2 PA 2
2 RA 5
1 IS Oper Supp Tech Sr

Special Records & Presentation
1 Vital Records Prog Supv
1 PA 4
2 PA 3
1 PA 2
1 RT 3
5 RT 2

Customer Services
1 PA Supv Adv
1 PA 4
1 PA 3
6 PA 2
1 PA 1

Total Positions: 91

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	EMS State Partnership Demonstration	DHHS	Continuation - Unchanged	$ 100,000		3/1/03	2/28/04	4 H33 MC 00097-03-02	2/28/03	$ 100,000
			Additional Authority - Unobligated		$ 44,837	3/1/03	2/28/04	6 H33 MC 00097-03-04	4/2/03	$ 44,837
DPH	Basic Emergency Lifesaving Skills In School EMS Targeted Issues Grant	DHHS	Continuation - Unchanged	$ 105,332 $ 94,668		3/1/03	2/28/04			
DPH	Basic Emergency Lifesaving Skills in School EMS Target Issues Grant	DHHS	Continuation - Modified Carry Over Request		$ 88,505	3/1/03	2/28/04	6 H34MC00123-02-01	9/17/03	$ 88,505
DPH	Universal Newborn Hearing Screening	DHHS	Continuation - Unchanged	$ 107,928		3/31/03	3/30/04	5 H61 MC 00024-04	3/26/03	$ 107,928
DPH	EMS Regional Symposium	DHHS	New	$ 18,850 $ 24,900		3/1/03	2/28/04	1 H33 MC 00145-01	3/19/03	$ 43,750
DPH	Tuberculosis Control Program	DHHS	Continuation - Unchanged	$ 449,600 $ 365,114		1/1/03	12/31/03	U52 / CCU500485-21-2	3/27/03	$ 507,597
DPH	Tuberculosis Epidemic Aid Assistance	DHHS	Amendment to Current Grant	$ 8,370		1/1/03	12/31/03	U52 / CCU500485-21-2	3/27/03	$ 8,370
DPH	Tuberculosis Program Supplemental Funds Outbreak Assistance Funds	DHHS	Amendment to Current Grant	$ 99,729		1/1/03	12/31/03	U52 / CCU500485-21-3	6/11/03	$ 99,729
DPH	STD Cooperative Agreement	DHHS	Continuation - Unchanged	$ 581,134 $ 769,565		1/1/03	12/31/03	H25 / CCH504344 - 12 H25 / CCH504344-13-1	12/26/02 4/1/03	$ 337,675 $ 1,013,024
DPH	STD Cooperative Agreement	DHHS	Amendment To Current Grant Supplemental DA		$ 102,499	1/1/03	12/31/03	H25 / CCH504344 - 13 -2	10/29/03	$ 102,499
DPH	HIV Prevention Cooperative Agreement	DHHS	Continuation - Unchanged	$ 1,053,926 $ 2,744,090		1/1/03	12/31/03	U62 / CCU502007-18-1	4/14/03	$ 3,798,016
DPH	HIV Prevention Cooperative Agreement	DHHS	Continuation - Modified Unobligated Fund Request		$ 192,557	1/1/03	12/31/03			
DPH	Immunization & Vaccines for Children	DHHS	Continuation - Modified		$ 2,153,468 $ 3,247,471	1/1/03 1/1/03	12/31/03 12/31/03	H23 / CCH522563-01 H23 / CCH522563-01-2	12/26/02 5/14/03	$ 1,454,273 $ 1,861,086
DPH	Immunization & Vaccines for Children	DHHS	Continuation - Modified Unobligated Funds from Year 12		$ 43,727	1/1/02	12/31/03	H23 / CCH504480-12-6	5/5/03	$ 43,727
DPH	Immunization & Vaccines for Children	DHHS	Continuation - Modified Supplemental Award		$ 37,287	10/1/03	12/31/03	H23 / CCH522563-01-5	11/4/03	$ 37,287

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	AIDS/HIV Surveillance Cooperative Agreement	DHHS	Continuation - Modified non-competitive continuation		$ 425,847	1/1/03	12/31/03			
DPH	AIDS/HIV Surveillance Cooperative Agreement	DHHS	Continuation - Unchanged 90 Day Extension	$ 123,279		1/1/04	3/31/04			
DPH	Mercury Contaminated Sport Fish Consumption Advisory Outreach Program	EPA	Continuation - Unchanged One Year No Cost Extension		$ 85,000	10/1/02	12/31/04			
DPH	Violence Against Women Planning and Implementation	DHHS	Continuation - Unchanged 90 Day No Cost Extension		$ 50,000	10/1/02	12/31/03	U17 / CCU522236-01-1	9/25/03	$ 50,000
DPH	State Based Birth Defects Surveillance Program	DHHS	Continuation - Unchanged Extension and Carry Forward	$ 100,500		9/1/03	8/31/04	U50 / CCU519233-03		
DPH	State-Based Occupational Surveillance New or Enhanced Models "Youth Employment Training Pilot Program"	DHHS	Continuation - Modified 7 Month Cost Extension		$ 49,908	10/1/03	4/30/04		9/11/03	$ 49,908
DPH	Bio-terrorism Hospital Preparedness Program	DHHS	New	$ 2,327,920		4/1/02	3/31/04	6 U3R MC 00017-01-03	12/16/02	$ 2,327,920
DPH	SOLEC Mercury Grant WIC Clinic Fish Consumption	EPA	Continuation - Unchanged 1 Year No Cost Extension		$ 156,906	10/1/01	9/30/04	GL97571801-1	10/16/03	$ 156,906
DPH	Lead Identification Research and Enforcement	EPA	Continuation - Unchanged 1 Year No Cost Extension		$ 100,500	2/1/02	2/1/05	X-97583201-1	10/16/03	$ 100,500
DPH	Ryan White Comprehensive AIDS Resources Emergency (CARE)	DHHS	Continuation - Unchanged	$ 3,522,828 $ 1,767,870		4/1/03	3/31/04			
DPH	Ryan White Comprehensive AIDS Resources Emergency (CARE)	DHHS	Continuation - Modified Carry Over Request from FFY02 to FFY03		$ 725,169	4/1/03	3/31/04			
DPH	Prevention Health & Health Services Block Grant	DHHS	Continuation - Unchanged	$ 1,509,710 $ 1,169,188		10/1/03	9/30/04	2003-B1-WI-PRVS-01 2003-B1-WI-PRVS-03	2/24/03 7/7/03	$ 2,678,898 $ 2,678,898
DPH	Cancer Prevention and Control Program	DHHS	Amendment to Current Grant Budget Revision	$ 3,151,995		6/30/03	6/29/04			
DPH	Cancer Prevention and Control Program	DHHS	Continuation - Modified Carry Over from Year 1 to Year 2		$ 47,402	6/30/03	6/29/04			
DPH	Basic Emergency Lifesaving Skills	DHHS	Continuation - Modified 1 Year Extension		$ 112,000 $ 88,000	2/28/03	2/28/04	1 U3RMC00017/01	3/1/02	$ 200,000

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	Epidemiology and Laboratory Capacity	DHHS	Continuation - Modified	$ 721,508 $ 1,314,322		7/1/03	6/30/04	U50/CCU514391-05	6/27/03	$ 1,977,206
DPH	Epidemiology and Laboratory Capacity West Nile Virus Surveillance and Response	DHHS	Amendment to Current Grant Supplemental Funding	$ 200,000		7/1/03	6/30/04			
DPH	Epidemiology and Laboratory Capacity SARS Surveillance and Response Activities	DHHS	Amendment to Current Grant Supplemental Funding	$ 229,608		7/1/03	6/30/04			
DPH	Indoor Radon Outreach Program Activities	EPA	Continuation - Unchanged	$ 243,070		6/1/03	5/31/04	K199501114-0	5/23/03	$ 243,070
DPH	Childhood Lead Poisoning Prevention	DHHS	Continuation - Modified	$ 128,700 $ 1,249,521		7/1/03	6/30/04	US7 / CCU522849-01	6/27/03	$ 1,237,596
DPH	State Cardiovascular Health Programs	DHHS	Continuation - Modified		$ 350,000	6/30/03	6/29/04	U50 / CCU521340-02	6/17/03	$ 350,000
DPH	State Cardiovascular Health Programs	DHHS	Continuation - Modified Carry Over From Year 1 to Year 2		$ 26,544	6/30/03	6/29/04			
DPH	Health Assessment of Great Lakes Sport Fish Consumption	DHHS	Continuation - Unchanged	$ 86,723 $ 125,989		9/30/03	9/29/04	H75 / ATH598322-12	8/20/03	$ 147,646
DPH	Occupational Safety & Health Training Program for Wisconsin Minority Youth	DHHS	New	$ 228,520		7/30/03	7/29/04			
DPH	Endocrine Disruptive Chemicals and Thyroid Outcomes	EPA	New revised to 4-year project	$ 128,043 $ 2,160,165		3/1/03	2/28/07	RD-83025401-0 RD-83025401-1	4/1/03 6/24/03	$ 743,710 $ 662,018
DPH	Public Health Conference Support Grant Program LOI A-79	DHHS	New	$ 18,848		9/15/03	9/14/04			
DPH	Early Childhood Comprehensive Systems CISS-SECSS	DHHS	New	$ 100,000		7/1/03	6/30/04	1 H25 MC 00232-01-0	7/7/03	$ 100,000
DPH	WIC Special Infrastructure Grant Purchase Hardware and Printers	USDA	New	$ 150,000		1/15/03	9/30/04		5/20/03	$ 150,000
DPH	WIC Special Infrastructure Grant Supplemental Funds: Infrastructure project	USDA	New	$ 132,840		1/15/03	9/30/04		10/27/03	$ 132,840
DPH	Chronic Disease Prevention & Health Promotion Programs	DHHS	New	$ 2,174,011		6/30/03	6/29/04	U58 / CCU522833-01	6/30/03	$ 3,635,144
DPH	Rape Prevention and Education	DHHS	Continuation - Unchanged	$ 116,727 $ 662,364		7/1/03	6/30/04	VF1 / CCV519925 02		$ 779,091

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	Mammography Quality Standards Act (MQSA) Mammography Inspections	US FDA	Continuation - Unchanged	$ 213,677		7/1/03	6/30/04	223-03-4449	7/1/03	$ 188,393
DPH	Early Hearing Detection and Intervention Tracking Referral & Coordination WE-TRAC	DHHS	Continuation - Unchanged	$ 148,000		9/1/03	8/31/04	UR3 / CCU520047-03	7/22/03	$ 148,000
DPH	Assess Multifaceted Fall Prevention Intervention Strategies in Community Dwellings	DHHS	Continuation - Unchanged	$ 104,024 $ 641,101		10/1/02	9/29/04	U17 / CCU522465-02	6/25/03	$ 745,125
DPH	Core Injury Program Development and Injury Surveillance Development	DHHS	Continuation - Unchanged	$ 75,000		9/30/03	9/29/04	U17 / CCU519383-04	9/13/03	$ 75,000
DPH	Surveillance of Hazardous Substances and Emergency Events	DHHS	Continuation - Unchanged	$ 84,478		9/30/03	9/29/04	U61 / ATU596961-13	8/20/03	$ 84,478
DPH	National Environmental Public Health Tracking System	DHHS	Continuation - Unchanged	$ 657,991		9/30/03	9/29/04	U50 / CCU522439-01		
DPH	Building Environmental Health Services Capacity in State & Local Dept of Public	DHHS	Continuation - Unchanged	$ 261,794		9/30/03	9/29/04	U38 / CCU520417-02		
DPH	Addressing Asthma From A Public Health Perspective Developing State Capacity	DHHS	Continuation - Unchanged	$ 245,108		9/30/03	9/29/04	U59 / CCU520846-02	5/28/03	$ 245,108
DPH	Addressing Asthma From A Public Health Perspective Developing State Capacity	DHHS	Continuation - Modified Carry Over Request-Year 2 to 3		$ 10,500	9/30/03	9/29/04	U59 / CCU520846-03	8/13/03	$ 10,500
DPH	Building State Capacity to Conduct Health Assessments	DHHS	Continuation - Modified		$ 456,710	9/30/03	9/29/04	U50 / ATU500005-16	8/20/03	$ 456,710
DPH	Primary Care Office Cooperative Agreement	DHHS	Continuation - Unchanged	$ 130,811		7/1/03	3/31/04	5 U68 CS 00228-16-0	6/25/03	$ 98,108
DPH	Rural Access to Emergency Devices	DHHS	Continuation - Unchanged	$ 241,006		9/1/03	8/31/04	1 H3DRH01219-01-00	9/5/03	$ 241,006
DPH	Rural Access to Emergency Devices	DHHS	Continuation - Modified Carry Over From Year 1 to Year 3		$ 10,328	9/1/03	8/31/04			
DPH	Minority HIV/AIDS Demonstration Grant	DHHS	Continuation - Unchanged	$ 55,000 $ 95,000		9/30/03	9/29/04			
DPH	Fatality Assessment & Control Evaluation (FACE)	DHHS	Continuation - Unchanged	$ 104,216		9/1/03	8/31/04	U60 / CCU507081-13	7/25/03	$ 104,216

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	Fatality Assessment & Control Evaluation (FACE)	DHHS	Continuation - Modified Carry Over From FFY03 to FFY04		$ 37,480	9/1/03	8/31/04	U60 / CCU507081-13-2	10/1/03	$ 37,480
DPH	State Systems Development Initiative (SSDI)	DHHS	Continuation - Modified		$ 100,000	9/30/03	9/29/06	2 H18MC00057-11-00	9/22/03	$ 100,000
DPH	Hospital Bioterrorism Preparedness Program	DHHS	Continuation - Modified	$ 9,180,277		9/1/03	8/31/04	2 U3RMC00017-02-00	9/12/03	$ 9,180,277
DPH	Trauma-EMS Systems Program	DHHS	Continuation - Unchanged	$ 40,000		8/1/03	7/31/04	5 H81MC00022-02-00	8/14/03	$ 40,000
DPH	Trauma-EMS Systems Program	DHHS	Continuation - Modified Carry Over Request		$ 4,639	8/1/03	7/31/04			
DPH	Public Health Preparedness and Response to Bioterrorism	DHHS	Continuation - Modified		$ 18,586,482	8/31/03	8/30/04	U90 / CCU517002-04	8/28/03	$ 18,586,482
DPH	Public Health Preparedness and Response to Bioterrorism	DHHS	Continuation - Modified Carry Over Request-FFY 03		$ 1,683,552	8/31/03	8/30/04			
DPH	Systems-Based Diabetes Prevention and Control Programs	DHHS	New	$ 701,716		4/30/03	3/29/04	U32 / CCU522717-01	5/5/03	$ 701,716
DPH	MOA - Farmers Market Nutrition Program Vendor Management	Dept of Agriculture	New	$ 5,100		2/1/03	12/31/03			
DPH	Population-Based Birth Defects Surveillance Programs	DHHS	New	$ 194,000		9/1/03	8/31/04			
DPH	Public Health Conference, Nov 17-18, 2003 "Assessing & Addressing Environmental Health: At Home, School, Work & Play"	DHHS	New	$ 18,848		7/1/03	6/30/04	C13 / CCC523027-01	9/4/03	$ 18,848
DPH	Development of the National Violent Death Reporting System	DHHS	New	$ 235,772		8/15/03	8/14/04	U17 / CCU523099-01	8/13/03	$ 235,772
DPH	Title V Maternal and Child Health Block Grant	DHHS	Continuation - Modified		$ 11,603,758	10/1/03	9/30/04			
DPH	OSHA Laboratory Contract	Dept of Labor	Continuation - Unchanged	$ 1,834,000		10/1/03	9/30/04	E9F4-2955	9/15/03	$ 1,834,000
DPH	Lead Accreditation, Certification and Enforcement Program	EPA	Continuation - Modified		$ 333,307	10/1/03	9/30/04	PB-97580303-0	9/19/03	$ 333,307

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	Commodity Supplemental Food Program	USDA	Continuation - Modified		$ 450,537	10/1/03	9/30/04			
DPH	Special Supplemental Nutrition Program for Women, Infants, & Children (WIC)	USDA	Continuation - Unchanged	$ 61,198,335		10/1/03	9/30/04			
DPH	OSHA Consultation	Dept of Labor	Continuation - Unchanged	$ 969,000		10/1/03	9/30/04	E9F4-1955	9/24/03	$ 969,000
DPH	Tuberculosis Control Program	DHHS	Continuation - Modified		$ 429,094	1/1/04	12/31/04			
DPH	Adult Blood Lead Epidemiology and Surveillance (ABLES) Program	DHHS	Continuation - Unchanged	$ 26,040		10/1/03	9/30/04			
DPH	State Based Programs To Reduce The Burden of Diabetes	DHHS	Continuation - Unchanged	$ 788,699		3/30/04	3/29/05			
DPH	WIC - Farmers' Market Nutrition Program	USDA	Continuation - Modified	$ 799,309		10/1/03	9/30/04			
DPH	EMS For Children Targeted Issues Grant	DHHS	Continuation - Unchanged	$ 200,000		3/1/04	2/28/05			
DPH	EMS For Children State Partnership Demonstration - 2004	DHHS	Continuation - Unchanged	$ 100,000		3/1/04	2/28/05			
DPH	STEPS to a HealthierUS: Reduce Burden of Asthma, Diabetes & Obesity	DHHS	New	$ 1,773,331		9/22/03	9/21/04			
DPH	Partnership for Healthy Babies in Wisconsin	USDA	New	$ 15,000		9/30/03	9/29/04	WI59-03-037	9/26/03	$ 15,000
DPH	Exposure to Tremolite Asbestos in Vermiculite Ore	DHHS	New	$ 176,000		9/15/03	9/14/04	U61 / ATU573213-01	9/8/03	$ 176,000
DPH	Environmental and Health Effect Tracking	DHHS	New	$ 352,290		9/15/03	9/14/04	U50 / CCU523286-01	9/15/03	$ 352,290
DPH	Advancing HIV Prevention Initiative (Contract)	DHHS	New	$ 1,068,483		9/30/03	9/29/05	200-2003-02369	9/11/03	$ 1,068,488
DPH	Head Start Innovation & Improvement Project "Healthy Smiles for Wisconsin Head Start"	DHHS	New	$ 972,223		1/1/04	9/30/07			
DPH	State Oral Health Collaborative Systems	DHHS	New	$ 100,000		9/1/03	8/31/04	H47MC01941	11/10/03	$ 100,000

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	Interpersonal Agreement: CDC and Chetna Mehrotra: Reimbursement for consultation on weight loss surgeries in WI	DHHS	New	$ 12,629		6/30/03	6/29/04			
DPH	Wisconsin Evidence-Based Promotion Programs For Older Adults	DHHS	New	$ 14,890		12/12/03	12/11/04			
				$ 114,200,603	$ 41,834,013					

Calendar Year PRF 2003 Total	$ 156,034,616
75 Active Grants	

Total Grants	88	$ 157,638,692
-PRF Grants	75	$ 156,034,616
-PR Grants	13	$ 1,604,076

Department of Health and Family Services
Division of Public Health Restructuring Report, Attachment 7
Summary of Continuation and New Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	School Health Programs - Improving the Health, Education & Well-being of Young People	WI - DPI	Continuation - Modified Continuing MOU from DPI		$ 122,830	3/1/03	2/28/04			
DPH	MOU - Improve the health of WI communities through collaboration in public health education	WI-UW Madison	New	$ 7,500		7/1/01	6/30/04			
DPH	Assessment of Mercury Exposure in WI	WI Focus On Energy	New	$ 160,017		5/15/03	6/30/05	03 005	5/13/03	$160,017
DPH	MOU - Providing Certified Lead Risk Assessor Services	WI - DOA	New	$ 197,697		1/1/03	12/31/04			
DPH	MOA - Provide Edpidemiology Support For The DHFS Minority Health Report	WPHHPI	New	$ 5,000		1/1/03	4/30/03			
DPH	Radiological Emergency Preparedness Program - Cooperative Agreement	WI Dept of Military Affairs	Continuation - Unchanged	$ 331,075		7/1/03	6/30/04	N/A	7/2/03	$331,075
DPH	Homeland Security Grant Program Equipment for State Agencies	WI - OJA	New	$ 170,906		5/1/03	10/31/04	HZ-03-ST-0077	9/29/03	$170,906
DPH	Refugee Health Funds	WI - DWD	New	$ 37,823		1/1/04	12/31/04			
DPH	Domestic Radiological Preparedness Sub Grant Agreement	WI Dept of Military Affairs	New	$ 53,000		9/15/03	12/31/03			
DPH	Minimizing Environmental Factors That Affect Asthma in Children	Environmental Council of States	New	$ 33,500		9/1/03	8/31/04			
DPH	Consultation Agreement With Health and Society Scholars Program	UW-Medical School	New	$ 2,500		9/1/03	8/31/04			
DPH	Domestic Preparedness Program Sub-Grant Purchase of Medication Training Kits and Medication	WI-Office of Justice Preparedness	New	$ 82,228		10/15/03	12/31/03		10/13/03	$ 82,228
DPH	American Legacy Foundation Cooperative Agreement	American Legacy Foundation	New	$ 400,000		9/1/03	6/30/04			
				$ 1,481,246	$ 122,830					

Calendar Year PR 2003 Total	$ 1,604,076
13 Active Grants	

Summary of Top 10 DPH Grant Awards

Division of Public Health Restructuring Report, Attachment 7

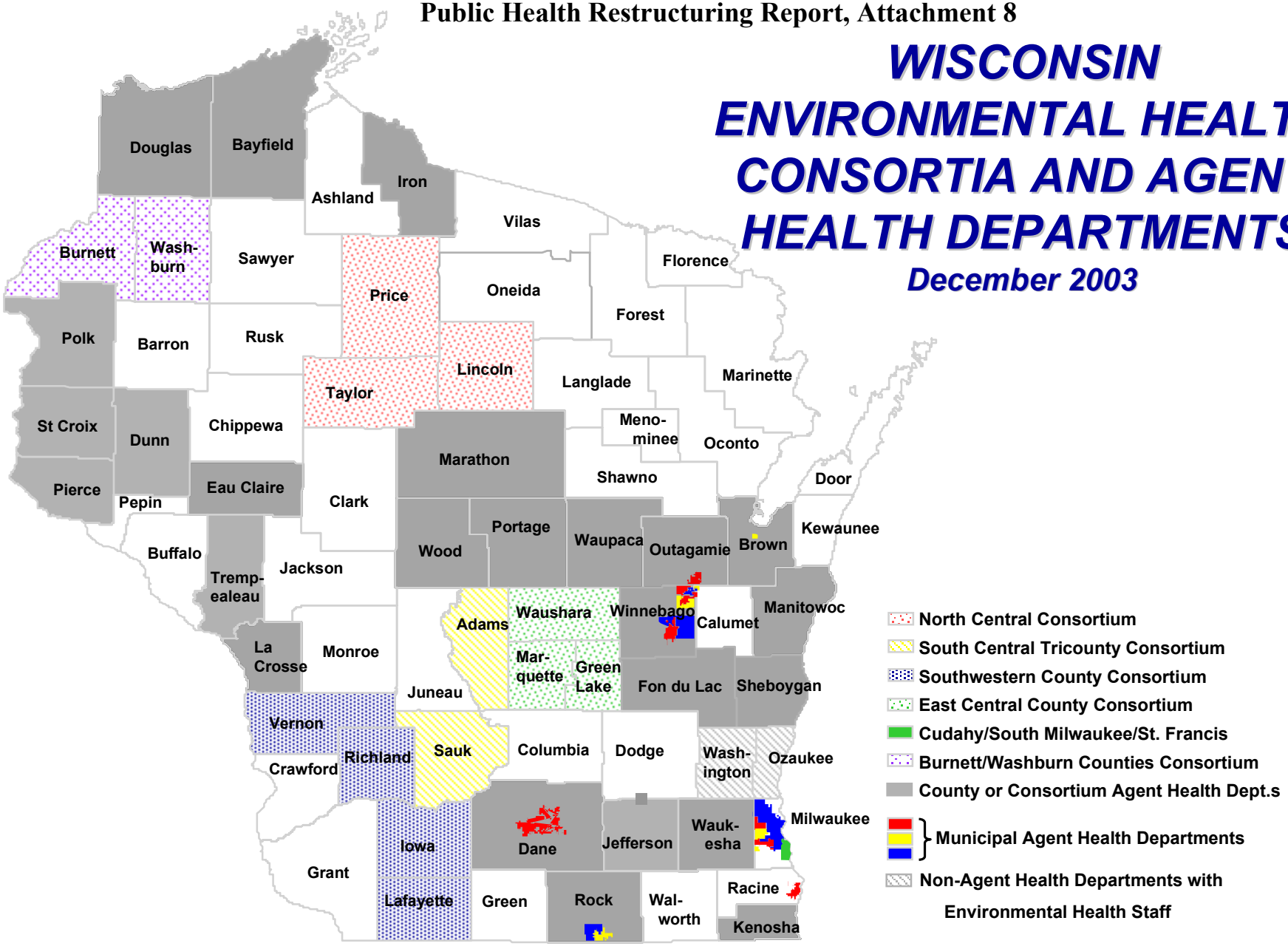
Calendar Year 2003

Program:	$ Awarded	Period of Funding From:	To:
Special Supplemental Nutrition Program for Women, Infants, & Children (WIC)	$ 61,198,335	10/1/03	9/30/04
Public Health Preparedness and Response to Bioterrorism	$ 20,270,034	8/31/03	8/30/04
Title V Maternal and Child Health Block Grant	$ 11,603,752	10/1/03	9/30/04
Hospital Bioterrorism Preparedness Program	$ 9,180,277	9/1/03	8/31/04
Ryan White Comprehensive AIDS Resources Emergency (CARE)	$ 6,015,867	4/1/03	3/31/04
Immunization & Vaccines for Children	$ 5,481,953	1/1/03	12/31/03
HIV Prevention Cooperative Agreement	$ 3,990,573	1/1/03	12/31/03
Cancer Prevention and Control Program	$ 3,199,397	6/30/03	9/30/04
Prevention Health and Health Services Block Grant	$ 2,678,898	10/1/03	9/30/04
Epidemiology and Laboratory Capacity	$ 2,465,438	7/1/03	6/30/04
Top 10 Grant Total	$ 126,084,524	80.0%	of Total Grant $'s

88 Active Grants	$ 157,638,692
-75 PRF Funded Grants	$ 156,034,616
-13 PR Funded Grants	$ 1,604,076

WISCONSIN ENVIRONMENTAL HEALTH CONSORTIA AND AGENT HEALTH DEPARTMENTS

December 2003



Public Health Restructuring Report
January 28, 2004
Attachment 9

Wisconsin Division of Public Health
State Law Requirements for Public Health Local Health Departments: Levels I, II, III

<u>Current</u> Basic Requirements for Services

Context:

This overview focuses on distinguishing the difference between the three different levels of local health departments. It is important to know that governance, administration and services are explicitly covered in other portions of ch. 251, related statutes and administrative rules as identified in the two sections that immediately follow.

Basic Legal Authority Relevant to the Local Health Department Requirements:

Ch. 252 Wis. Stats. – Communicable Diseases
Ch. 253 Wis. Stats. – Maternal and Child Health
Ch. 254 Wis. Stats. – Environmental Health
Ch. 255 Wis. Stats. – Chronic Disease and Injuries
Ch. 146 Wis. Stats. – Miscellaneous Health Provisions (includes the patient health care record statute)

All other related DHFS Rules relate to the above or to other state level governmental agencies who are "partners" to the Wisconsin Division of Public Health (e.g., Department of Agriculture, Trade, and Consumer Protection, Department of Natural Resources, Department of Public Instruction, Department of Administration, etc.)

Five Required Services of all Local Health Departments

1. Communicable disease surveillance, prevention and control
2. Generalized public health nursing program
3. Health promotion
4. Disease prevention
5. Human health hazard prevention and control

<u>Level I Local Health Department Rule Requirements for Services</u>

1. Provide or arrange for all five basic public health services to the community –
   - Communicable disease surveillance, prevention and control
   - Generalized public health nursing program
   - Health promotion
   - Disease prevention
   - Human health hazard prevention and control

2. Voluntarily adhere to the framework for the generalized public health nursing program

3. Reports –
   - Submit annual report for the preceding calendar year if required by the local governing body
   - Submit annual survey of data that responds to the format as prescribed public health data system
   - Submit activities of the local health departments for the preceding year that describes progress and performance toward achieving the objectives that the local health department had identified as part of its community assessment process.

4. Optional Services –
   - May provide any services that a Level II or Level III local health department provides (e.g., agent status)

Level II Local Health Department Rule Requirements for Services

1. Provide or arrange for all five basic public health services to the community –
   - Communicable disease surveillance, prevention and control
   - Generalized public health nursing program
   - Health promotion
   - Disease prevention
   - Human health hazard prevention and control

2. Provide or arrange for the provision of services that address at least one objective from sections 2-8 of *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000.* Show evidence for all of the following:
   - Each objective is selected through a process based on assessed need, community involvement and participation, and formally recognizes that objective is a public health priority for the community.
   - The local health department identifies resources or services that it will commit to achieving the objective.
   - That contemporary public health practices of proven merit are being used to provide services to the community to achieve the objectives.
   - The local health department has established a process whereby it will evaluate and report to the community on progress and performance toward achieving the objectives.

3. Voluntarily adhere to the framework for the generalized public health nursing program.

4. Reports –
   - Submit annual report for the preceding calendar year if required by the local governing body
   - Submit annual survey of data that responds to the format as prescribed public health data system
   - Submit a report, in a format prescribed by the Department of Health and Family Services, on activities of the local health department for the preceding calendar year, including a narrative that describes the progress and performance toward achieving the objectives identified as part of its community health assessment, and that are linked to one objective from each section 2-8 in *Healthier People in Wisconsin*.

5. Optional Services –
   - May provide any services of a Level III local health department (e.g., agent status)

Level III Local Health Department Rule Requirements for Services

1. Provide or arrange for all five basic public health services to the community –
   - Communicable disease surveillance, prevention and control
   - Generalized public health nursing program
   - Health promotion
   - Disease prevention
   - Human health hazard prevention and control

2. Provide or arrange for the provision of services that address at least three objectives from sections 2-8 of *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000.* Show evidence for all of the following:

   - Each objective is selected through a process based on assessed need, community involvement and participation, and formally recognizes that objective is a public health priority for the community.
   - The local health department identifies resources or services that it will commit to achieving the objective.
   - That contemporary public health practices of proven merit are being used to provide services to the community to achieve the objectives.
   - The local health department has established a process whereby it will evaluate and report to the community on progress and performance toward achieving the objectives.

3. Voluntarily adhere to the framework for the generalized public health nursing program.

4. Voluntarily adhere to the framework for an environmental health program.

5. Reports –
   - Submit annual report for the preceding calendar year if required by the local governing body
   - Submit annual survey of data that responds to the format as prescribed public health data system
   - Submit a report, in a format prescribed by the Department of Health and Family Services, on activities of the local health department for the preceding calendar year, including a narrative that describes the progress and performance toward achieving the objectives identified as part of its community health assessment, and that are linked to three objectives from each section 2-8 in *Healthier People in Wisconsin*.

Designation of Local Health Departments – HFS 140.07

This section requires the Department of Health and Family Services to formally review the operations of all local health departments in a county or municipality at least every five years. The review shall result in a written finding as to whether the requirements for a level I, II, or III local health department has been met. These written findings shall address recommendations regarding staffing, functions, and practices. It also should address the timeframe for correction (not to exceed one year), technical resources to assist the local health department, and formal re-review to assure that deficiencies have been corrected.

Public Health Restructuring Report, Attachment 10

DIVISION OF PUBLIC HEALTH

FUNDS CONTRACTED WITH UW SYSTEM

AS OF OCTOBER 2003

Description	PO or CARS Contract	Contract Start Date	Contract End Date	Contract Amount
Basic Emergency Lifesaving Skills in Shcools (BELSS)	CARS	3/1/03	2/29/04	**$80,664**
Environmental Capacity Building	CARS	10/1/02	9/30/03	**$29,037**
Tobacco Research Clearinghouse	CARS	1/1/03	12/31/03	**$175,000**
AIDS/HIV Prevention	PO			$5,517
AIDS/HIV Ryan White	PO			$30,000
Hepatitis C	PO			$9,675
				$45,192
Marshfield Molecular Epi	PO			**$30,002**
Diabetes Control	CARS	7/1/02	3/31/03	$23,500
Well Woman Program	CARS	10/1/02	6/30/03	$35,000
				$58,500
Indoor Radon	CARS	6/1/02	5/31/03	**$24,613**
Birth Defects (BDOMP)	CARS	7/1/02	6/30/03	$7,453
Congenital Disorders	CARS	7/1/03	6/30/04	$32,300
Statewide Projects	CARS	1/1/03	12/31/03	$330,000
				$369,753
Congenital Disorders	CARS	7/1/03	6/30/04	$223,992
Statewide Projects	CARS	1/1/03	12/31/03	$235,023
				$459,015
Environmental Health Capacity Startup	CARS	10/1/02	9/30/03	**$5,000**
Mascola Position	CARS	10/1/02	3/31/03	$14,400
Congenital Disorders	CARS	7/1/03	6/30/04	$76,836
Fall Prevention	CARS	10/1/02	9/30/03	$390,016
HIV Home/Community Care (RW)	CARS	4/1/03	3/31/04	$52,000
HIV Home/Community Care (RW)	CARS	1/1/03	12/31/03	$13,000
Oral Health Data Collection	CARS	9/1/02	2/28/03	$15,000
				$561,252
Universal Newborn Hearing Screening	CARS	4/1/02	3/31/03	$7,836
SPHERE Data System (MCH)	CARS	7/1/03	9/30/03	$75,000
NEDSS base system implementation	CARS	7/1/03	6/30/04	$289,400
Early Hearing Detection	CARS	9/1/03	8/31/04	$67,156
Birth Defects (BDOMP)	CARS	1/1/03	8/31/03	$47,466
Bioterrorism - Helth Alert Network	CARS	9/1/02	8/31/03	$1,526,923
Bioterrorism Focus B - Epi/Surv Capacity	CARS	9/1/02	8/31/03	$75,000
Asthma	CARS	4/1/03	9/30/03	$25,000
Environmental Health Tracking	CARS	10/1/02	9/30/03	$175,000
Bioterrorism - Training	CARS	9/1/02	8/31/03	$138,261
Bioterrorism Focus B - Epi/Surv Capacity	CARS	8/1/03	7/31/04	$27,000
Bioterrorism - Training	CARS	9/1/02	8/31/03	$9,252
Bioterrorism - Training	CARS	9/1/02	11/30/03	$91,242
Bioterrorism - Training	CARS	7/1/03	7/31/04	$25,872
Bioterrorism - Training	CARS	7/1/03	7/31/04	$24,000
SPHERE Data System (MCH)	CARS	10/1/02	9/30/03	$123,155
				$2,727,563

Public Health Restructuring Report, Attachment 10

DIVISION OF PUBLIC HEALTH

FUNDS CONTRACTED WITH UW SYSTEM

AS OF OCTOBER 2003

Description	PO or CARS Contract	Contract Start Date	Contract End Date	Contract Amount
Birth Defects (BDOMP)	PO			$14,740
Asthma	PO			$11,100
Birth Defects Prevention	PO			$10,000
Cardiovascular	PO			$30,000
Cardiovascular	Direct Voucher			$9,257
Cardiovascular	PO			$5,000
Diabetes	PO			$5,000
Tobacco Control	PO			$9,370
Immunization	Direct Voucher			$4,750
				$99,217
Aresenic Evaluation	CARS	10/1/02	9/30/03	**$13,850**
HIV Prevention	CARS	10/1/02	9/30/03	$155,000
HIV Prevention	CARS	1/1/03	12/31/03	$115,000
				$270,000
Diabetes	CARS	5/1/03	3/31/04	$22,917
Diabetes	CARS	7/1/02	4/30/03	$31,583
Childhood Lead Poisoning Prevention	CARS	7/1/03	6/30/04	$352,986
Childhood Lead Poisoning Prevention	CARS	7/1/02	6/30/03	$345,967
Fish Consumption Study	CARS	10/1/03	9/30/04	$61,180
WIC Fish Study	CARS	10/1/02	9/30/03	$93,015
Fish Outreach	CARS	11/1/02	10/31/04	$83,000
Mercury Exposure	CARS	7/1/03	6/30/04	$35,287
Endocrine Study	CARS	6/1/03	2/29/04	$127,828
				$1,153,763
Mercury Exposure	CARS	7/1/03	6/30/04	**$21,721**
Tobacco Young Adult Pilot	CARS	1/1/03	12/31/03	**$25,000**
Tobacco Quit Line	CARS	1/1/03	12/31/03	$1,000,000
Tobacco Employer Cessation	CARS	4/1/03	12/31/03	$177,500
Tobacco Cessation Outreach	CARS	7/1/02	6/30/03	$1,000,000
Tobacco Cessation Outreach	CARS	11/1/02	6/30/03	$475,272
Tobacco Cessation Outreach	CARS	1/1/03	12/31/03	$273,698
				$2,926,470
Tobacco Policy & Technical Assistance	CARS	4/1/03	12/31/03	$90,000
Tobacco Monitoring & Evaluation	CARS	1/1/03	12/31/03	$1,115,000
Cancer Control	CARS	1/1/04	12/31/04	$20,215
Cancer Evaluation	CARS	7/1/03	6/30/04	$106,969
Tobacco Melvin Surveillance	CARS	7/1/02	6/30/03	$100,000
Tobacco TA Consultants	CARS	1/1/02	3/31/03	$78,435
Technical Assistance Advisory	CARS	1/1/03	12/31/03	$142,189
				$1,652,808
WI Well Women Program	PO			$24,500
Marshfield Molecular Epi				$9,782
				$34,282
Obesity & Cardiovascular	CARS	7/1/02	6/30/03	$30,790
HIV Prevention	CARS	9/1/03	5/31/04	$18,000
				$48,790

Public Health Restructuring Report, Attachment 10

DIVISION OF PUBLIC HEALTH

FUNDS CONTRACTED WITH UW SYSTEM

AS OF OCTOBER 2003

Description	PO or CARS Contract	Contract Start Date	Contract End Date	Contract Amount
Environmental Testing	CARS	7/1/02	6/30/03	$38,600
Radioactive Testing	CARS	7/1/03	6/30/04	$86,537
Lead Hazard Control	CARS	6/1/02	5/31/03	$5,725
STD	CARS	9/1/03	8/31/04	$180,000
Communicable Surveillance	CARS	7/1/03	6/30/04	$58,306
Infrant Hep B	CARS	1/1/03	12/31/03	$34,400
Lead Poisoning	CARS	7/1/03	6/30/04	$83,400
Fish Consumption Study	CARS	7/1/03	9/30/03	$146,281
TB Control	CARS	1/1/03	12/31/03	$38,960
PAP Testing	CARS	1/1/04	12/31/04	$410,700
Newborn Screening	CARS	7/1/03	6/30/04	$66,000
Bioterrorism Planning	CARS	9/1/02	8/31/03	$50,000
Early Hearing Detection	CARS	9/1/02	8/31/03	$12,000
Bioterrorism Preparedness	CARS	9/1/02	8/31/03	$1,637,460
Bioterrorism - Health Alert Network	CARS	9/1/02	8/31/03	$321,712
Bioterrorism - Epi & Surveillance	CARS	9/1/02	8/31/03	$100,000
TB Control - Demo Project	CARS	1/1/03	12/31/03	$36,820
TB Control	CARS	1/1/02	12/31/03	$58,760
Environmental Health Tracking	CARS	10/1/02	9/30/03	$38,000
Influenza Surveillance	CARS	7/1/03	6/30/04	$60,420
Food/Waterborne Surveillance	CARS	7/1/03	6/30/04	$26,750
Epi & Lab Capacity	CARS	7/1/03	6/30/04	$3,300
Hep C	CARS	7/1/03	6/30/04	$72,126
West Nile	CARS	7/1/03	6/30/04	$51,880
HIV CTS	CARS	7/1/03	6/30/04	$305,000
HIV "PHIPP"	CARS	10/1/03	9/30/04	$80,000
Endocrine Study	CARS	6/1/03	2/29/04	$284,000
				$4,287,137
Newborn Screening	PO			$55,000
Newborn Screening	PO			$30,000
OSHA Lab	PO			$1,814,000
				$1,899,000
Milw Family Project Training	CARS	1/1/03	12/31/03	$40,000
Tobacco Surveillance & Evaluation	CARS	7/1/03	6/30/04	$25,000
Bioterrorism Planning	CARS	9/1/02	8/31/03	$74,735
				$139,735
MCH - Wisline services	PO			**$20,000**
Immunization - Wisline services	PO			$17,190
Various Progs - Wisline services	Direct Voucher			$22,962
				$40,152
Tobacco - Young Adult Pilot Study	CARS	1/1/03	12/31/03	**$550,000**
TOTAL				**$17,747,517**

Public Health Restructuring Project
January 28, 2004
Attachment 11

Options Considered by function and program/organizational areas

CURRENT PUBLIC HEALTH FUNCTIONS IN DPH & BHI	PROGRAMS	BUREAU LOCATION	OPTION – ELIMINATE FUNCTION	OPTION – REDUCE EFFORT/ STREAM-LINE ADMIN. WITHIN DHFS	OPTION – PUBLIC HEALTH INSTITUTE	OPTION – LOCAL ADMIN.	OTHER OPTIONS
1.Grant and program development	Almost all	All		x	x		x
2. Contract administration	All	All bureaus and regions		x			
3. Operating Budget management	Budget and Fiscal Mgt.	Operations					
4. Fiscal admin. - processing payments	Budget and Fiscal Mgt.	Operations					
	EMS Funding Assistance	BEMSIP	x	x			x
5. Program Support	All	All					
6. Supervision	All	All					
7. Policy Development	All programs	All		x	x		x
8. Program Evaluation	All areas	All		x	x		x
	State Public Health Plan	OPHI		x	x		x
	SYNAR	BCDPHP			x	x	
9. Research studies			x		x		x
10. IT	All	All		x	x		x
11. Data base management	Most programs	Most areas		x			
12. Licensing/ certification / enforcement of individuals				x		x	x
	Food Manager Certification	BEH		x			x
	Sanitarian Registration	BEH		x			x
	First Responders	BEMSIP		x			x

Public Health Restructuring Project
January 28, 2004
Attachment 11

Options Considered by function and program/organizational areas

CURRENT PUBLIC HEALTH FUNCTIONS IN DPH & BHI	PROGRAMS	BUREAU LOCATION	OPTION – ELIMINATE FUNCTION	OPTION – REDUCE EFFORT/ STREAM-LINE ADMIN. WITHIN DHFS	OPTION – PUBLIC HEALTH INSTITUTE	OPTION – LOCAL ADMIN.	OTHER OPTIONS
	Asbestos & Lead Abatement - Certification, Accreditation and Notification	BOH		x		x	
13. Regulation of establishments							
	Food, Lodging and Recreational Licensing	BEH				x	x
	Radioactive Materials	BEH		x			
	x-ray device regulation	BEH				x	x
	Mammography Quality Standards	BEH					
	EMS licensing and certification	BEMSIP		x			x
	WIC Vendor authorization	BFCH		x			x
	Tattoo parlors	BEH				x	x
	Tanning bed regulation	BEH	x			x	
14. Surveillance	All areas	Include BHI		x	x	x	x
15. Epidemiology.	All	Include BHI		x	x	x	x
16. Field Investigation	Multiple programs including environmental health			x		x	x
17. Client follow-up	7+ programs	Most		x		x	x
18. Professional consultation/ technical assistance	All	All		x		x	x

Public Health Restructuring Project
January 28, 2004
Attachment 11

Options Considered by function and program/organizational areas

CURRENT PUBLIC HEALTH FUNCTIONS IN DPH & BHI	PROGRAMS	BUREAU LOCATION	OPTION – ELIMINATE FUNCTION	OPTION – REDUCE EFFORT/ STREAM-LINE ADMIN. WITHIN DHFS	OPTION – PUBLIC HEALTH INSTITUTE	OPTION – LOCAL ADMIN.	OTHER OPTIONS
19. Public information/ health promotion	All	All		x	x	x	x
20.Training	All	All		x	x	x	x
Other areas reviewed							
Regional Offices				x		x	
Bioterrorism/ PH & Hospital Preparedness		All except BFCH		x	x	x	x
Office of Public Health Improvement			x	x	x		x
	Rape Prevention/ Sexual Assault Grant	BEMSIP		x	x		x
	Lead Registry	BOH	x				
	Population-based chronic disease programs	BCDPHP		x	x		x
	Organ Donor Awareness Program	BCDPHP			x		x
	Primary Care Cooperative Agreement	BCDPHP –					x
	AIDS/HIV	BCD		x	x	x	x
	WIC	BFCH		x	x	x	x
MCH Block Grant				x	x		x
	Children with Special Health Care Needs (CSHCN)	BFCH		x	x	x	x
Prevention Block Grant							x
Food/ Commodity distribution program	TEFAP	BFCH		x			x

Public Health Restructuring Report
January 28, 2004
Attachment 12

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
	Priority 1. **Implement major systems and organizational changes**				
1.	Simplify the performance based contracting with local health departments. *No statutory requirements*	This will free up staff time - estimate is that about 100 DPH staff are involved in some aspect of this – across central office and regions This will also free up staff time in local health departments	Begin work with existing steering committee of state and local staff to identify requirements, examine alternatives and make recommendations for CY05 and CY06 contracts Develop budget language by 5/15/04, if necessary	Implement recommended changes for CY 05 contracts	Implement other changes in CY 06 contracts if a two year transition is necessary
2.	Move the Bureau of Health Information to DPH.		Develop budget proposal by 5/15/03 and work under a MOU in the meantime that establishes governance, funding and priorities	Finalize the transfer in the budget bill eff. 7/1/05	
3.	Realign and integrate governance of Information Technology functions in DPH and BHI. *No statutory language – possible DOA guidelines forthcoming*	DPH has a few dedicated FTEs who manage IT work It is a part of the job of many other people in both DPH and BHI.	Winter/Spring 2004 – work with DMT to develop IT governance structure Integrate management of contracts and application development activities in DPH Align with BHI		

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
4.	Establish a Wisconsin Public Health Institute. *Assuming statutory language will be needed*	Current contracting arrangements with UW provide over $17 million – number of current positions funded at the University is not known	Spring 2004 – develop budget proposal to create either a PH Authority or a 501(c)3 corporation Continue the ad-hoc relationship with UW Public Health and Health Policy Institute so that current projects can continue, newly funded projects that fit within the Institute's mission can get underway Consider a more formal arrangement with the UW for the short term as a way to seek out new revenue sources Consider shifting other work now done in DPH to the University ahead of the creation of a formal PH Institute	January to late in 2005 - continue the ad-hoc relationship with UW Public Health and Health Policy Institute so that projects can continue, newly funded projects that fit within the Institute's mission can get underway while making the transition to a new institution Implement budget provisions to establish an Institute including shift of positions from DHFS to the Institute effective with the approval of the budget	Expand scope of services provided by the PHI Seek out new revenue sources
5.	Require by law that local health departments regulate restaurants and other establishments and establish a statewide fee schedule to fully fund the service in all parts of the state.	Estimate is 25 – 27 FTEs across the central office and DPH regions Staffing inventory shows 46.5 FTE total funded by program	Promote voluntary transition until law can be changed – create incentives including bundling of funding streams, more flexibility on contracts and new options for regional consortia Prepare budget request by 5/15/03 to mandate the shift and to	July 2005 – Create authority and establish fee schedule in the Budget Bill Need lead time to make the transition – consider phased approach for January	Complete transition

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
			establish the fee schedule, work with associations interested in this issue and work with the DATCP to develop ideas to streamline state services	2006 (and January 2007 if needed) based on criteria developed with local agencies	
6.	Move other direct services now performed by state staff including field investigations and direct client follow-up for AIDs/HIV and STDs to local government. These are now performed by DPH staff for environmental health investigations, partner notification for AIDs/HIV and STDs, radiation protection, ATSDR site assessments. *Assuming statutory language will be needed*	Environmental health investigations (focus is clean indoor air) – now done by 2 FTEs with GPR funding Partner notification: - STDs 1 state FTE and 2 federal assignees in Madison 5 state and 3 federal assignees in Milwaukee - AIDs/HIV – 3 FTE based in Milwaukee Local health departments handle this in the rest of the state	Promote voluntary transition – create incentives including bundling of funding streams, more flexibility on contracts and new options for regional consortia		
7.	Examine the current consortia structures to identify options that provide maximum flexibility to local government and reduce overhead, including reducing central office effort to shift funds for Public Health Preparedness to local government.	Proposal is to reduce central office staff for Public Health Preparedness by 4 – 6 FTEs to free up funding for local government.	Work with local health departments to identify requirements, examine alternatives and make recommendations for CY05 and CY06 contracts Develop budget language by 5/15/04, if necessary		

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
8.	Bundle funding streams for local government to the extent possible to provide maximum flexibility and to assure core funding for community priorities.	This will reduce staff effort	Begin analysis of how funds are used, propose other models, identify changes in law needed to implement Prepare budget request by 5/15/04, if needed Tie this effort to the shift in regulatory functions and other direct services, new options for regional consortia and incentives to consolidate local health departments		
9.	Create incentives to consolidate local health departments	This would reduce staff effort	Begin analysis of how funds are used, propose other models, identify changes in law needed to implement Prepare budget request by 5/15/04, if needed Tie this effort to other related recommendations regarding performance based contracting, consortia options and realigning funding streams.		
10.	Consider options to realign federal funding streams to provide better support for the core functions of public health	None anticipated	Begin analysis of how funds are used, propose other models, and identify changes in law needed to implement.	July 2005 – Create authority and establish fee schedule in the Budget Bill	

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
	and both the state and local level and to align spending with health priorities – including shifting EMS services to fees.		Prepare budget request by 5/15/04, if needed., working with DOA and DOT on a proposal to add a fee to the driver's license to support EMS Tie this effort to the shift in regulatory functions and other direct services, new options for regional consortia and incentives to consolidate local health departments	Collect the fees beginning with January 2006 so that the realignment of funding streams can occur at that time.	
11.	Streamline the DPH organization and integrate it with the Bureau of Health Information	FTEs savings by consolidation of bureaus, elimination of some units and by streamlining the functions within the new bureaus.	Spring 2004 – seek DOA approval of reorganization plan By June 2004 – eliminate some positions, restructure funding in others and reassign remaining staff – assumes the new structure would be effective 7/1/04 For Children with Special Health Care Needs Program, analysis of options can begin immediately		
12.	Assess opportunities to streamline the division of labor across state agencies.		Analysis can begin immediately - Develop chronology of past initiatives & current status with analysis of problems encountered Prepare budget proposal by 5/15/04, if needed		

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
13.	Simplify the internal process for awarding grants	Estimate is savings of FTE across many positions that can be used to absorb the new work associated with adding more vendors to the delivery system	Begin analysis of how funds are used, propose other models, and identify changes in law needed to implement. Prepare budget request by 5/15/04, if needed, working with DOA and DOT on a proposal to add a fee to the driver's license to support EMS - Tie this effort to the shift in regulatory functions and other direct services, new options for regional consortia and incentives to consolidate.		
14.	Conduct a feasibility study about adding WIC to the Food Stamp EBT platform	Unknown- major benefit is savings in administrative costs	Analysis can begin immediately.		
15.	Analyze options for a private contractor for WIC vendor certification functions	Estimate is 5 – 6 FTE out of the total staffing of 8.5 FTE in central office	Analysis can begin immediately.		
16.	Analyze options for a contract with UW Extension for WIC nutrition education	There are now 7 FTEs in the WIC nutrition unit plus several other nutrition positions in the Bureau. Contract with UW-Extension is for nutrition services to low income families in 58counties, with total funding for FFY 2004 of $12.7 million	Analysis can begin immediately.		

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
	Priority 2. Reduce effort/ streamline central office operations				
1.	Discontinue the regulation of tanning beds *s. 255.08 "may"*	.2 FTE devoted to this at this time	Develop budget proposal by 5/15/04 Work with DOA on budget proposal	7/05 – law needs to be changed in the budget bill	
2.	Eliminate the Lead Registry *s. 254.179*	7 FTEs in central office	Develop budget proposal by 5/15/04 Work with DOA on budget proposal	7/05 – law needs to be changed in the budget bill	
3.	Eliminate the program for Reproductive Hazards in the Workplace	I FTE in the Bureau of Occupational Health that is funded by MCH block grant	Discretionary activity – can be done in first six months of 2004		
4.	Shift EMS providers to a longer renewal cycle and stagger renewal dates; contract for the issuance of EMS licenses. *s. 146.50 (10) – licensing of ambulance service providers and emergency medical technicians is due July 1 of each even numbered year*	A longer and staggered cycle would save 520 hours – the time requested of other bureaus to assist in the processing of license renewals this year. There are 4 FTEs dedicated to EMS licensing full time and another 3 employees who spend a part of their time on this function	Analysis can begin immediately. Develop budget proposal by 5/15/04		

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
		The section now has 15 FTEs to license EMS providers (450) and EMTs (15,000) with new and 2 year renewals; supervise and coordinate the EMS system statewide. The section also certifies first responders/handles rural defibrillator grants.			
5.	Simplify the process for awarding grants to EMS providers. *s. 146.55 (4)* *identical base and supplement based on population*	.5 FTE now handling this function	Analysis can begin immediately. Develop budget proposal by 5/15/04		
6.	Modify OSHA consultation services.	There is now a unit of 10 FTEs with 3 engineers plus an engineer manager that conducts about 325-onsite inspections/yr.	Analysis can begin immediately.		
7.	Reduce effort spent on publications.	This will save staff time that can be reassigned to higher priority work	Department-wide review of printing and publications process is currently being conducted by OPRA. Recommendation for improving the process will be included in report to be completed in February.		

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
8.	Establish/expand a contract for food distribution for the Temporary Emergency Food Assistance Program.	Possibly .5 FTE There is one position now to manage this program.	Review past contracting history, identify other options for contracting.		
9.	Determine if the Department of Regulation and Licensing can issue credentials to Registered Sanitarians *s. 250.05(5) – language required*	.1 - .2 FTE dedicated to this function	Analysis can begin immediately. Develop budget proposal by 5/15/04		
10.	Determine if the Department of Regulation and Licensing or a private contract can be developed for Food Manager Certification. *s. 254.71(2) "MAY" language required*	Estimate is that about .75 – 1 FTE is devoted to this function now	Work with DOA and DRL to determine feasibility before the budget writing process begins. Budget proposal by 5/15/04, if needed.		
11.	Sort out responsibilities within DHFS between DCFS for the Brighter Futures Program and the pregnancy prevention and related programs in DPH. *Language likely required*		Analysis can begin immediately		

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
12.	Sort out responsibilities within DHFS between DDES and DPH for fall prevention programs for seniors. *Language likely required*		Analysis can begin immediately		
13.	Complete the planned reduction in the number of "Ryan White Consortia" from six to one.	Now one FTE handling this – possibly reduce by .5 FTE			
	Priority 3. Devolve other public health functions to local government				
1.	Move inspection of x-ray machines to local government. *Assuming statutory language will be needed*	7.3 FTE all based in central office *Total radiation protection staff 24.35 FTEs??*	Prepare budget request by 5/15/04.	July 2005 – Create authority in the Budget Bill Need lead time to make the transition – consider phased approach for January 2006 (and January 2007 if needed) based on criteria developed with local government	
2.	Move some case specific screening and case management functions in the adult and child lead programs.	Adult lead program: .3 FTE (Federal funds) in the Bureau of Environmental Health	Prepare budget request by 5/15/04.	July 2005 - create authority in the Budget Bill	

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
	Assuming statutory language will be needed	Child lead program: 2.5 FTE plus contractual staff operated by Bureau of Occupational Health		Need lead time to make the transition – consider phased approach for January 2006 (and January 2007 if needed) based on criteria developed with local government	
3.	Move some asbestos and lead abatement functions. *Assuming statutory language will be needed*	5.5 FTE for asbestos abatement – supported by fees 4.6 FTE for lead abatement – also supported by fees Both programs in the Bureau of Environmental Health	Prepare budget request by 5/15/04.	July 2005 - create authority in the Budget Bill Need lead time to make the transition – consider phased approach for January 2006 (and January 2007 if needed) based on criteria developed with local government	
4.	Move some occupational health functions to local government after environmental health is well established *Assuming statutory language will be needed*	Current unit in the Bureau of Occupational Health includes 10 FTEs	Prepare budget request by 5/15/04.	July 2005 - create authority in the Budget Bill Need lead time to make the transition – consider phased approach for January 2006 (and January 2007 if needed) based on criteria developed with local government	

Impact and Timing of Implementation Activities for all Recommendations

	Recommendations ***Statutory reference, if relevant***	***FTE impact, if known***	***January 2004 - December 2004***	***January 2005 – December 2005***	***January 2006 & Beyond***
5.	Shift funding in the Well-woman program to permit use of GPR in the program for case management services *s. 255.06 requires that the Department implement a Well-Woman program to do all of the following..* *does not appear to be prohibitive language*	none	Prepare budget request by 5/15/04 to change the appropriation schedule	As it requires action in biennial budget make it effective with the next round of contracts after 7/05	
6.	Expand the role of local government in specific population-based functions including training, epidemiology and professional consultation	This is intended to create additional capacity – not to reduce DPH staffing	Can be done now and there is funding available now to create positions in each regional Public Health Preparedness Consortia for training and for epidemiology		